Maternal and Child Health Data and Services Report

Washington State Department of Health

Maternal and Child Health Assessment

January 2006

Washington State Department of Health

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Maternal and Child Health
Data and Services Report

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This report could not have been accomplished without the help and support of the many contributing authors, reviewers and data providers listed below. The MCH Assessment section in the Office of Maternal and Child Health remains responsible for the accuracy and format. Any questions should be directed to the authors listed above.

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We sincerely thank and greatly appreciate the assistance of the following people who helped draft portions of the document.

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This report is supported in part by the MCH Block Grant (B04MC04238) from the Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration, and State Systems Initiative (SSDI) grant (H18MC00054) through the Department of Health and Human Services.

Suggested Citation: Washington State Department of Health. Maternal and Child Health Data and Services Report. Olympia, WA. 2006 Jan. 218 p. Available at:
http://devwww/cfh/mch/mch_assessment/mchdatareport/mch_data_report_home.htm

Acknowledgements:

We also greatly appreciate the assistance of the following people who provided data, reviewed drafts, and made extremely helpful comments as we developed this report.

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Introduction

The Maternal and Child Health Data and Services Report is intended to be a resource primarily for public health professionals on the health status and service needs of pregnant women, infants, children and adolescents in Washington State. The Health Resources and Services Administration (HRSA), the federal granting agency for the Maternal and Child Health Block Grant (Title V), requires annual reporting of a number of health measures to track the health status of the maternal and child health population (See Appendices B and C). This report is an ongoing attempt to put these measures into broader context and to use this information to develop and evaluate programs and policies. Chapters are designed to be used individually as fact sheets or together, and will be updated periodically as new data are added to the datasets used.

The first section, Health Outcomes and Health Behaviors, contains an initial chapter with county-specific population information as well as trend tables of pregnancy outcomes and infant and child mortality. Subsequent chapters focus on topics relevant to the MCH population, relying primarily on graphs and charts to provide a snapshot of how the Washington State population looks. Each chapter provides data that describe the MCH population overall as well as by county, age, gender, race and ethnicity, rural and urban residence and Medicaid status where available. Yearly data from 1980 through 2003 have been included, when available.

The second section, Publicly Funded Social and Health Services, describes several social, medical and preventive health services targeted for pregnant women, women of reproductive age, infants, children and/or adolescents in Washington. This section has been added in response to an evaluation of the previous data report. It is intended to help the Office of Maternal and Child Health monitor the state's capacity to address the health needs of the MCH population in Washington. Each chapter addresses what the service is, how or where it is provided, who is eligible for the service, who is receiving the service, and what issues or concerns exist regarding the service. As this is the first time all of this information has been provided in a single location and format, some inconsistencies persist, and it is likely that some services which should have been included were overlooked. Our goal is that this section will be updated and will improve over time as staff use this information. Ultimately, we hope to be able to address regional challenges in service provision as well.

The third and final section of the report includes appendices. Appendix A includes technical notes on the data sources used, analytic definitions and statistical information. Appendices B and C, respectively, include information on the MCH priorities and MCH Block Grant required performance and outcome measures.

Washington State Population and Birth Counts, 2003

County	WA Population [1]	Population 0-19 Years [1]	Women 15-17 Years [2]	Live Births [3]	Singleton Live Births [3]
State Total	**6,098,300**	**1,695,826**	**128,888**	**80,482**	**78,029**
Adams	16,600	6,057	448	339	329
Asotin	20,600	5,630	502	287	275
Benton	151,600	48,133	3,871	2,190	2,128
Chelan	67,900	20,338	1,560	888	876
Clallam	65,300	15,531	1,324	609	597
Clark	372,300	113,498	8,162	5,332	5,171
Columbia	4,100	1,042	92	37	35
Cowlitz	94,900	27,162	2,094	1,141	1,120
Douglas	33,600	10,588	850	432	427
Ferry	7,300	2,118	198	70	70
Franklin	53,600	19,925	1,418	1,322	1,298
Garfield	2,400	657	68	16	16
Grant	77,100	26,531	1,996	1,431	1,401
Grays Harbor	68,800	18,961	1,609	817	802
Island	74,000	20,012	1,459	947	927
Jefferson	26,700	5,518	496	226	220
King	1,779,300	433,621	31,804	22,431	21,636
Kitsap	237,000	67,902	5,317	3,014	2,915
Kittitas	35,200	8,997	633	380	367
Klickitat	19,300	5,507	465	232	224
Lewis	70,400	20,039	1,681	839	807
Lincoln	10,100	2,667	255	84	84
Mason	50,200	12,696	1,113	569	561
Okanogan	39,600	11,649	997	485	481
Pacific	20,900	4,777	411	188	182
Pend Oreille	11,800	3,255	316	107	105
Pierce	733,700	215,846	16,250	10,085	9,785
San Juan	14,800	2,939	236	88	83
Skagit	106,700	30,273	2,434	1,356	1,324
Skamania	9,900	2,808	248	114	112
Snohomish	637,500	186,823	13,971	8,592	8,279
Spokane	428,600	120,933	9,393	5,455	5,293
Stevens	40,600	12,278	1,149	467	451
Thurston	214,800	58,848	4,860	2,619	2,558
Wahkiakum	3,800	922	94	29	27
Walla Walla	55,800	15,727	1,214	686	678
Whatcom	174,500	47,884	3,571	2,035	1,968
Whitman	41,000	10,804	659	410	394
Yakima	22,600	76,929	5,668	4,133	4,023

1. Office of Financial Management, Intercensal and Postcensal Estimates of County Population by Age and Sex: 1980-2003; June 2004
2. Center for Health Statistics Washington State Department of Health, Washington State Pregnancy and Induced Abortion Statistics 2003, "Table 28. Female Population by Age and County of Residence", 3/2005. Website: http://www.doh.wa.gov/ehsphl/chs/chs-data/abortion/download/a_tb_28.xls
3. Vital Registration System. Annual Statistical Files, Birth Certificate Data: Washington State Department of Health, Center for Health Statistics (CHS), 1980-2003

Pregnancy Outcomes Washington State Residents, 1983 – 2003 [1]

Year	Women 15-44	Pregnancy Number	Pregnancy Rate [2]	Live Births Number	Live Births Rate [2]	Abortion Number [3]	Abortion Rate [2]	Fetal Death Number	Fetal Death Ratio [2,4]
1983	1,029,728	95,827	93.1	68,794	66.8	26,560	25.8	473	6.9
1984	1,042,868	96,325	92.3	69,059	66.2	26,732	25.6	444	6.4
1985	1,060,994	96,595	91.0	70,357	66.3	25,835	24.3	403	5.7
1986	1,073,622	97,008	90.4	69,572	64.8	26,991	25.1	445	6.4
1987	1,087,405	99,887	91.9	70,409	64.7	29,067	26.7	411	5.8
1988	1,103,463	102,216	92.6	72,660	65.8	29,175	26.4	381	5.2
1989	1,123,342	106,435	95.0	75,595	67.0	30,452	27.0	388	5.0
1990	1,152,242	110,543	96.0	79,468	69.0	30,613	26.6	462	5.8
1991	1,183,653	110,778	93.6	79,962	67.6	30,390	25.7	426	5.3
1992	1,197,928	109,267	91.2	79,897	66.7	28,922	24.1	448	5.6
1993	1,215,051	107,971	88.9	78,771	64.8	28,804	23.7	396	5.0
1994	1,227,406	105,141	85.7	77,368	63.0	27,330	22.3	443	5.7
1995	1,243,506	104,309	83.9	77,240	62.1	26,650	21.4	419	5.4
1996	1,257,029	104,732	83.3	77,874	62.0	26,396	21.0	462	5.9
1997	1,271,209	105,653	83.1	78,141	61.5	27,055	21.3	457	5.8
1998	1,279,437	105,724	82.6	79,640	62.2	25,613	20.0	471	5.9
1999	1,285,708	106,010	82.5	79,577	61.9	25,965	20.2	468	5.9
2000	1,292,589	107,504	83.2	81,004	62.7	26,063	20.2	437	5.4
2001	1,298,668	105,958	81.6	79,542	61.2	25,998	20.0	418	5.3
2002	1,300,286	104,883	80.7	79,003	60.8	25,446	19.6	434	5.5
2003	1,298,673	106,086	81.7	80,482	62.0	25,106	19.3	498	6.2

1. Center for Health Statistics, Washington State Department of Health, "Trend Table – Pregnancy Statistics", 1/2005. Website: http://www.doh.wa.gov/ehsphl/chs/chs-data/abortion/download/Intro_tb2.xls
2. Rates equal total pregnancies, births, or abortions per 1,000 women of childbearing age (15-44). The fetal death ratio is equal to total fetal deaths per 1,000 live births.
3. Abortions for 1992-1995 include: 1,262; 1,234; 1,316; and 1,346 estimated abortions that were not reported in original published reports.
4. Fetal death reporting is required only when the gestational period is twenty weeks or more.

Washington State Mortality By Year, 1980-2003

	Perinatal Fetal plus 0-6 days[1]		Neonatal 0-27 days[1]		Postneonatal 28-364 days[1]		Infant 0-364 days[1]		Child 1-19 years[3]	
Year	Number	Rate[2]	Number	Rate[2]	Number	Rate[2]	Number	Rate[2]	Number	Rate[4]
1980	na	na	482	7.1	320	4.7	802	11.8	695	56.8
1981	na	na	444	6.3	291	4.2	735	10.5	622	50.5
1982	na	na	431	6.2	324	4.7	755	10.8	609	49.6
1983	na	na	376	5.5	280	4.1	656	9.5	531	43.5
1984	na	na	374	5.4	328	4.8	702	10.2	583	47.8
1985	na	na	433	6.2	316	4.5	749	10.6	571	46.6
1986	na	na	375	5.4	301	4.3	676	9.7	577	46.8
1987	na	na	365	5.2	318	4.5	683	9.7	611	49.1
1988	na	na	335	4.6	321	4.4	656	9.0	604	47.7
1989	na	na	383	5.1	311	4.1	694	9.2	537	41.4
1990	na	na	333	4.2	289	3.6	622	7.8	544	41.0
1991	na	na	315	3.9	288	3.6	603	7.5	511	37.4
1992	667	8.3	291	3.6	249	3.1	540	6.8	502	35.8
1993	589	7.4	247	3.1	248	3.2	495	6.3	536	37.1
1994	651	8.4	275	3.6	203	2.6	478	6.2	557	37.7
1995	635	8.2	259	3.4	190	2.5	449	5.8	520	34.4
1996	704	9.0	292	3.8	175	2.3	467	6.0	504	32.6
1997	664	8.4	263	3.4	177	2.3	440	5.6	524	33.3
1998	692	8.6	285	3.6	167	2.1	452	5.7	479	30.1
1999	674	8.4	257	3.2	144	1.8	401	5.0	488	30.3
2000	628	7.7	248	3.1	175	2.1	423	5.2	470	29.3
2001	652	8.2	292	3.7	169	2.1	461	5.8	454	28.1
2002	657	8.3	287	3.6	165	2.1	452	5.7	473	29.2
2003	734	9.1	302	3.8	145	1.8	447	5.6	454	28.1

1. Center for Health Statistics. Washington State Department of Health, 1980-2003. "Infant Mortality Table F8", 1/2005. Website: http://www.doh.wa.gov/ehsphl/chs/chs-data/infdeath/download/InfantF8.xls
2. Rates are per 1,000 live births
3. Vital Registration System. Annual Statistical Files, Birth Certificate Data: Washington State Department of Health, Center for Health Statistics (CHS), 1980-2003.
4. Rate per 100,000 children 1-19 years

Adolescent Pregnancy [a]

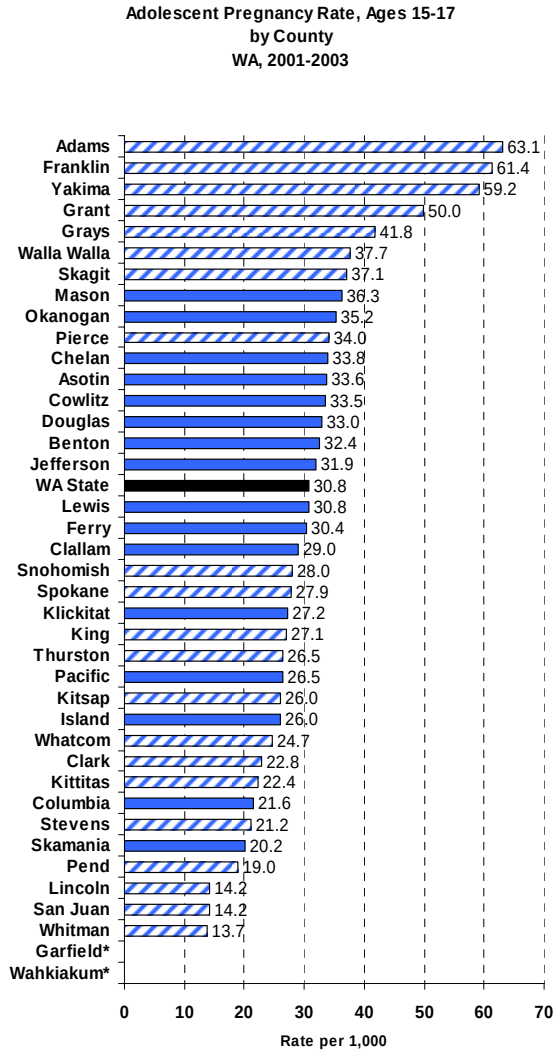
Publicly funded services to address Adolescent Pregnancy are described in Family Planning and Teen Pregnancy Prevention

Key Findings

- Washington's adolescent pregnancy rate in 2003 was 28.8 per 1,000 women ages 15-17 years. This represented 3,710 pregnancies. The most recent national rate available is the 2000 adolescent pregnancy rate of 53.5 per 1,000.[1,2,3]
- Washington's adolescent pregnancy rate was significantly lower than the 1990 rate of 57.9 per 1,000 women ages 15-17.[1,b]
- Approximately 53% of adolescent pregnancies resulted in live births for a total of 1,976 births in 2003. The Washington adolescent birth rate was 15.3 per 1,000 women in 2003, compared to the national rate of 22.4 per 1,000 women ages 15-17 years.[1,3]
- Reliable data on adolescent abortions by race and ethnicity are not available, so race and ethnicity data from live births are presented here. Adolescent birth rates are significantly higher in Blacks and American Indian/Alaska Natives compared to other racial groups while Hispanics have a significantly higher adolescent birth rate compared to non-Hispanic teens.[b]
- The Healthy People 2010 objective is for no more than 43 pregnancies per 1,000 women 15-17 years old. Washington's 2003 rate meets this objective.[4]

Definition: Adolescent pregnancies are estimated by adding together reported births, induced abortions, and fetal losses for women ages 15-17 years. Spontaneous abortions (miscarriages) occurring prior to 20 weeks gestation are not included because there is no way of accurately estimating them.

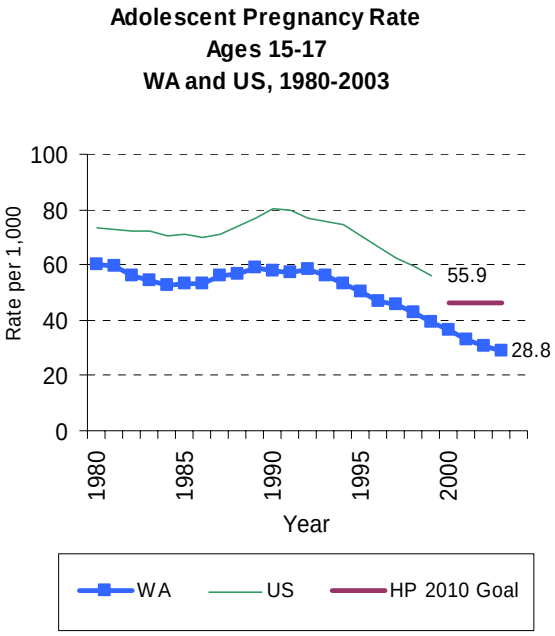
County [1,b]



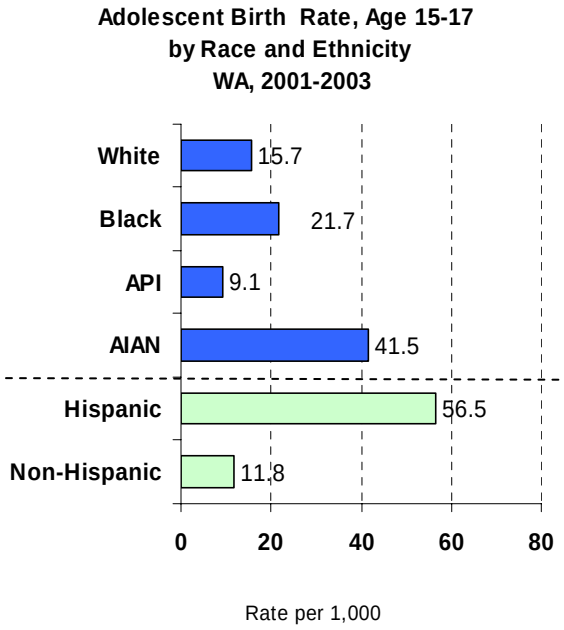
**County rates not calculated if less than 5 events*

Significantly different from state based on 95% confidence intervals

Time Trend [1,2,5]



Race and Ethnicity (Live Births) [6,c,d]



Data Sources

1. Washington State Pregnancy and Induced Abortion Statistics 2003. Washington State Department of Health, Center for Health Statistics.
2. Ventura SJ, Abma JC, Mosher WD, et al. Estimated pregnancy rates for the US, 1990-2000 : An Update. National Vital Statistics Reports; Vol 52 No 23. Hyattsville, MD: National Center for Health Statistics, 2004. Website: http://www.cdc.gov/nchs/data/nvsr/nvsr52/nvsr52_23.pdf
3. Martin JA, Hamilton RE, Sutton PD, et al. Births: Final data for 2003. National Vital Statistics Report; Vol 54 No 2. Hyattsville, Maryland: National Center for Health Statistics, 2003. Website: http://www.cdc.gov/nchs/data/nvsr/nvsr54/nvsr54_02.pdf
4. Department of Health and Human Services (US). Healthy People 2010: Understanding and Improving Health. 2nd edition. Washington DC: US Government Printing Office; November 2000.
5. Ventura SJ, Mosher WD, Curtin SC, et al. Trends in pregnancies and pregnancy rates by outcome : Estimates for the United States, 1976-1996. National Center for Health Statistics. Vital Health Statistics; Vol 21 No 56. Hyattville, Maryland: National Center for Health Statistics, 2000. Website: http://www.cdc.gov/nchs/data/series/sr_21/sr21_056.pdf.
6. Washington State birth certificate data: Vital Statistics 2003, Washington State Department of Health, Center for Health Statistics, 2003.

Endnotes

a. In this section, adolescents are 15-17 year olds unless otherwise indicated. Analysis was restricted to 15-17 year olds because they are school age. Pregnancy among women younger than 15 is a rare event and women older than 17 are at a lower risk for poor birth outcomes.
b. Significance is based on 95% Confidence Intervals.
c. API – Asian/Pacific Islander
d. AIAN – American Indian/Alaska Native

Alcohol Use Before and During Pregnancy

Publicly funded services to address Alcohol Use During Pregnancy are described in Substance Abuse Services for Pregnant Women

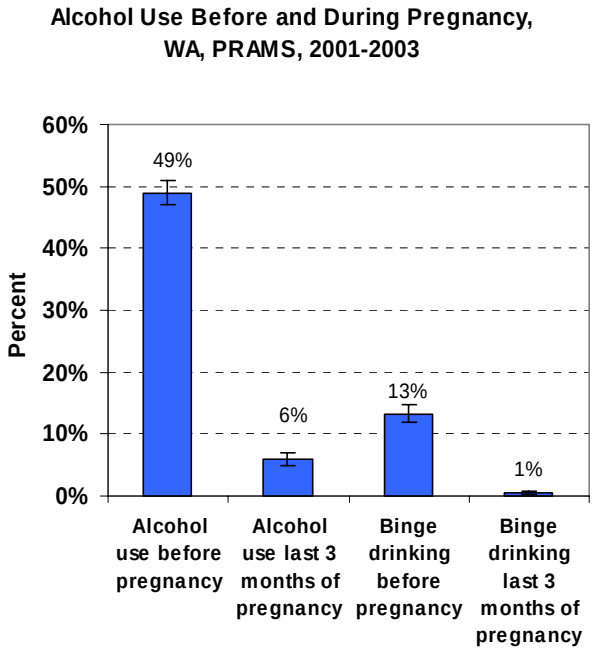
Definition: Alcohol use is defined as any drink of alcohol during the time in question. Binge drinking is defined as 5 or more alcoholic drinks at one sitting. These data are self-reported from the 2001-2003 Pregnancy Risk Assessment Monitoring System (PRAMS) based on the average number of alcoholic drinks per week during the three months before the woman got pregnant and the last three months of her pregnancy.

Key Findings

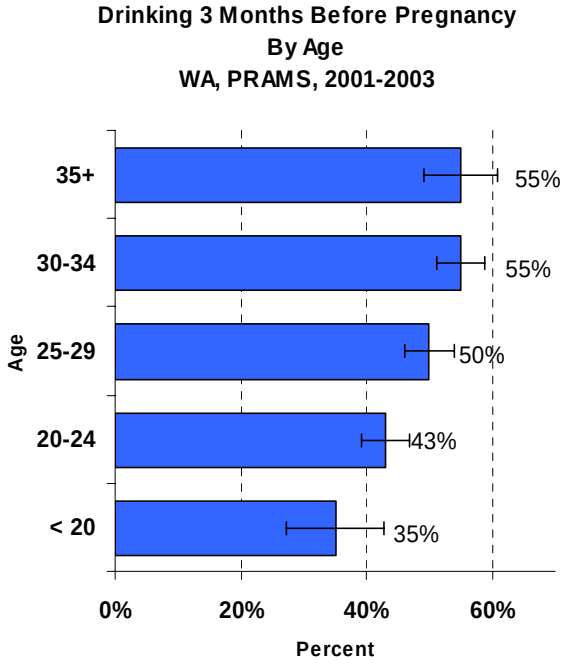
- Maternal prenatal alcohol exposure is one of the leading preventable causes of birth defects and developmental disabilities. Embryos and fetuses exposed to alcohol can develop a wide range of disorders from subtle physical and mental effects to severe mental retardation. There is no safe amount of alcohol, nor a safe time, that a woman can drink while pregnant. Alcohol use in the three months prior to pregnancy is collected as women may not realize they are pregnant for several weeks.
- From 2001-2003, an estimated 49% of new mothers reported drinking alcohol during the three months before becoming pregnant, and 6% reported drinking alcohol during their third trimester of pregnancy.[1]
- Drinking in the three months prior to pregnancy was most common among women over 30 years (55%). Among the youngest mothers, over one-third reported drinking before pregnancy.[1]
- An estimated 13% of new mothers reported binge drinking during the 3 months before they got pregnant while less than 1% reported binge drinking the last 3 months of pregnancy.[1]
- Women who intended to become pregnant were significantly less likely to binge drink before they became pregnant than women who did not intend to become pregnant. (Data not shown.)[1]
- Hispanic women were significantly less likely to report drinking before pregnancy than women of other races/ethnicities.[1,a]
- Non-Medicaid women were significantly more likely to report drinking before pregnancy and during the 3rd trimester than women receiving Medicaid regardless of Medicaid program.[1, 2]
- Women with more than a high school education were the most likely to report drinking during 3rd trimester (~9%). There was no difference in reported binge drinking during the third trimester by mother's educational status (Data not shown).[1,a]
- The Healthy People 2010 objective is for at least 94% of pregnant women to abstain from alcohol and 100% to abstain from binge drinking during pregnancy. Washington has not yet met the HP2010 objective.[3]

Alcohol Use In Pregnancy By Maternal Age

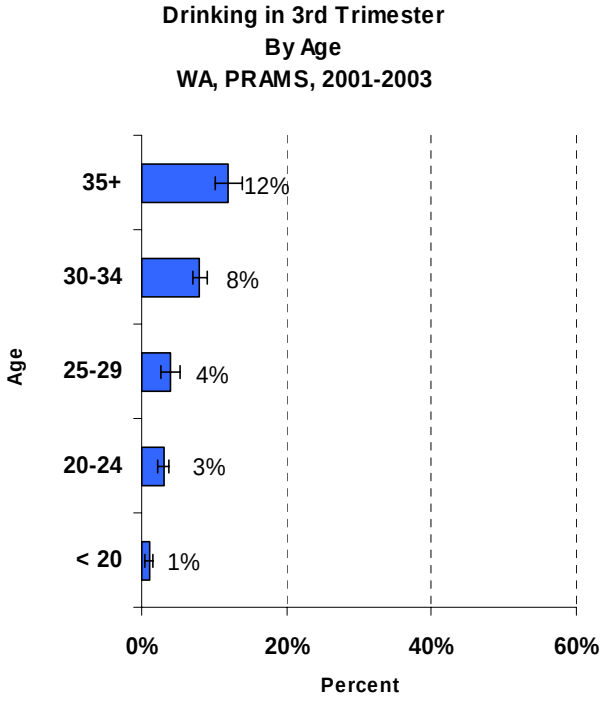
Overall [1]



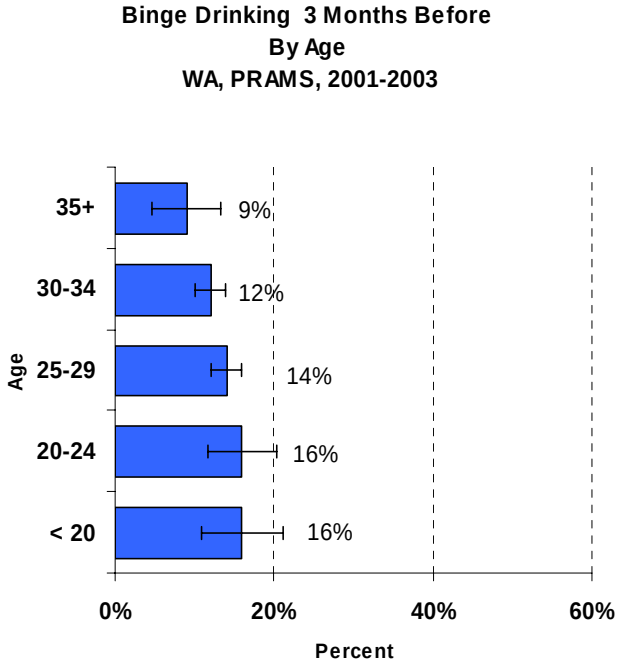
Before Pregnancy [1]



Third Trimester [1]

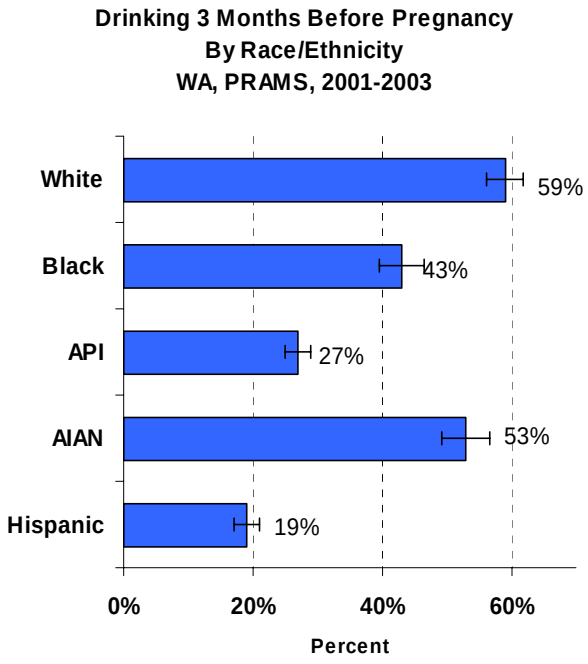


Binge Drinking [1]

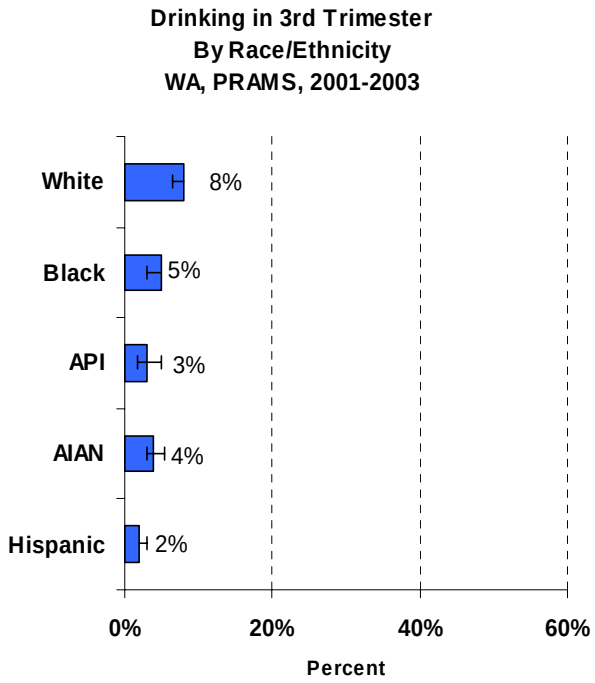


Alcohol Use in Pregnancy by Race and Ethnicity

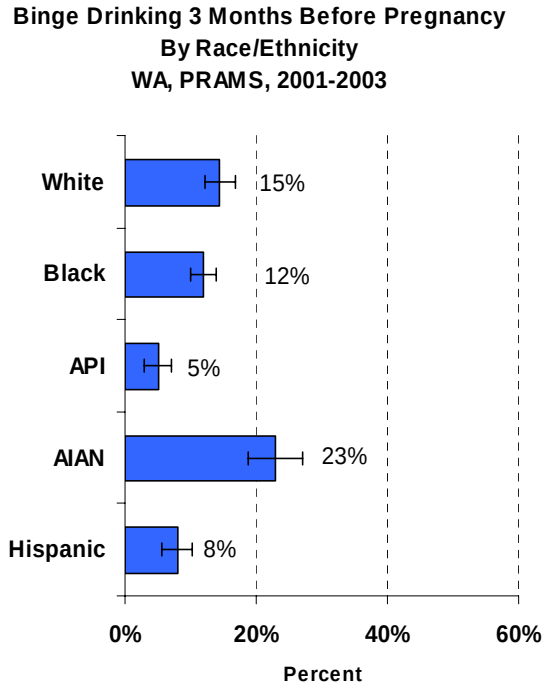
Before Pregnancy [1,a,b,c]



Third Trimester [1,a,b,c]

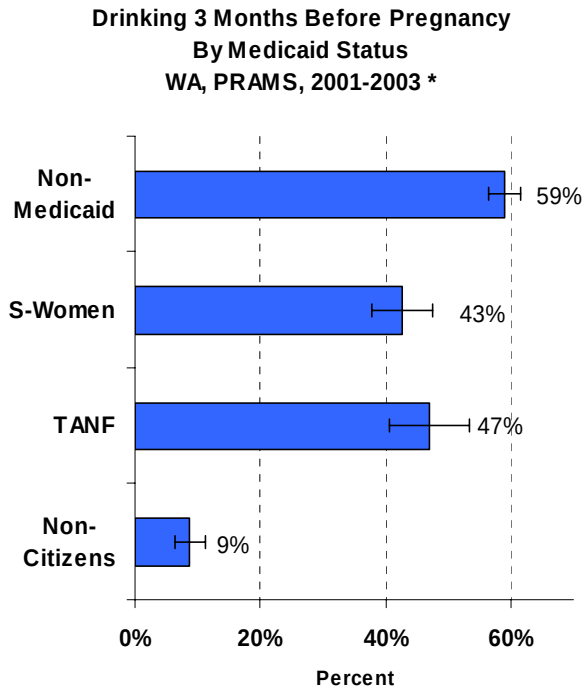


Binge Drinking [1,a,b,c]

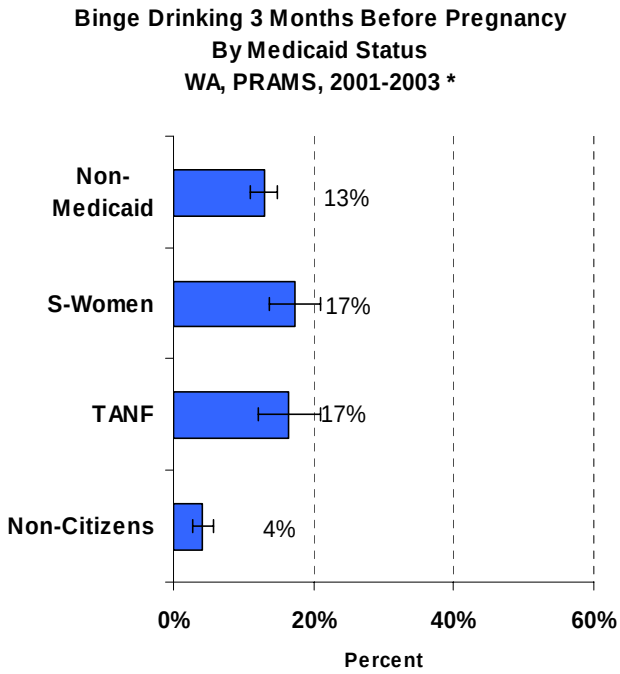


Alcohol Use in Pregnancy by Medicaid Status

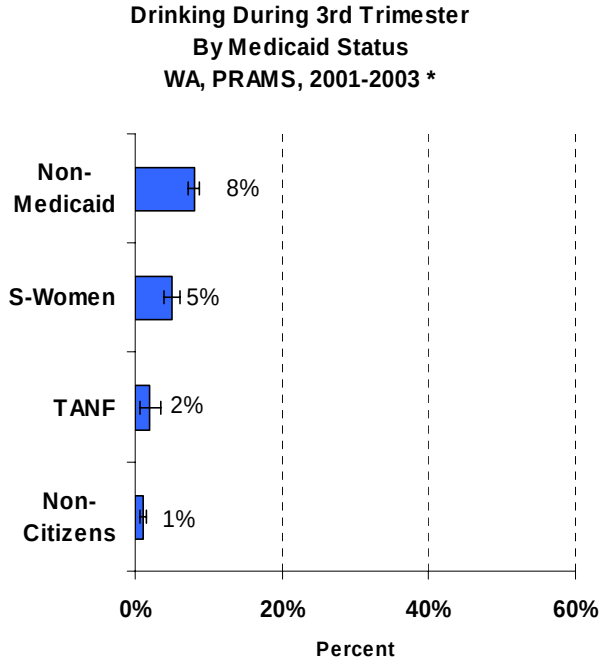
Before Pregnancy [1,2,a]



Third Trimester [1,2,a]



Binge Drinking [1,2,a]



***** Medicaid women received maternity care paid for by Medicaid. They are divided into three major subgroups (from highest to lowest socioeconomic status): **S-Women** - those women are citizens and eligible to receive Medicaid because they are pregnant and have incomes at or below 185% FPL, **TANF** - those women who are very low income (generally < 50% FPL) and receive cash assistance (TANF) in addition to Medicaid, and **Non-Citizens** - those women who are not citizens and are eligible to receive Medicaid because they are pregnant and have incomes at or below 185% FPL. Non-citizens are not eligible for TANF although their incomes are often lower than women on TANF. All three Medicaid groups have incomes below most Non-Medicaid women.

Data Sources

1. Washington Pregnancy Risk Assessment Monitoring System (PRAMS), 2001-2003, Washington State Department of Health.
2. First Steps Database, Research and Data Analysis Division, Washington State Department of Social and Health Services.
3. Department of Health and Human Services (US). Healthy People 2010: Understanding and Improving Health. 2nd edition. Washington, DC: US Government Printing Office; November 2000.

Endnotes

a. Significance was determined based on 95% Confidence Intervals
b. AIAN – American Indian/Alaska Native
c. API – Asian or Pacific Islander

Asthma

Publicly funded services to address Asthma are described in Early and Periodic Screening, Diagnosis and Treatment, and Care Coordination.

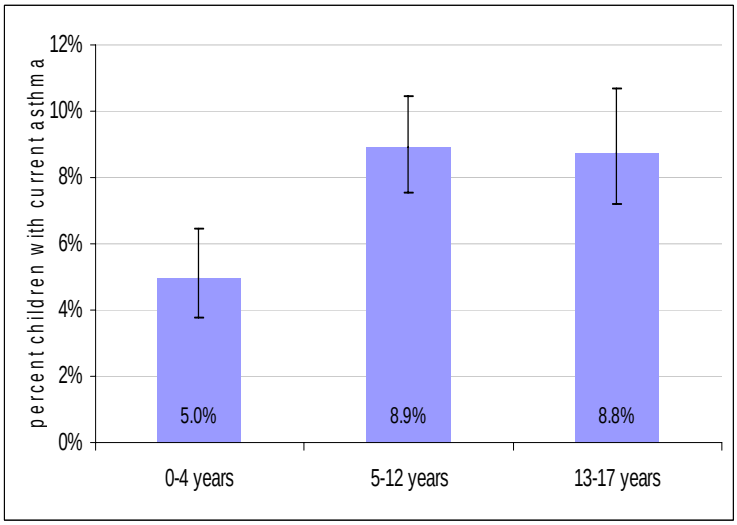
Definition: Asthma is a chronic inflammatory disease of the airways characterized by airway obstruction.

Key Findings:

- About 120,000 Washington youth are currently affected by asthma.[1]
- One in ten households with children of any age has a child with asthma.[1]
- The prevalence of asthma among Washington state youth is higher than the US rate and is increasing.[1]
- In 2004, between 7-10% of middle/high school-aged children had asthma.[1]
- Parents reported current asthma prevalence of about 5% for children ages 0-4, and 9% for children ages 5-12 and 13-17.[1,2]
- Among young children, asthma prevalence is higher for boys than for girls; by middle school age these differences reverse. In 2004, girls were significantly more likely than boys to have current asthma (11% compared to 7%). (Data not shown)
- Among Washington youth, Asians and Hispanics were less likely than White non-Hispanics to have asthma, but there were no significant differences among non-Hispanic whites and other groups.[1,3]
- Youth with moderate or severe persistent asthma are significantly less likely to report high academic achievement and more likely to miss school than are youth with mild asthma or no asthma.[1]
- Asthma hospitalization rates are significantly higher in urban areas than suburban or small town/rural areas.[1,4] (Data not shown)
- Few Washington state secondary schools provide a full-time registered nurse.
- Washington legislation allowing all students to self-carry/self-administer asthma and anaphylaxis medication at all school functions was passed in 2005.
- Washington has not yet met the Healthy People 2010 objectives for asthma to reduce deaths from asthma for children ages <5 and 5-14 to no more than 0.1 per 100,000; and for ages 15-34 to no more than 0.2 per 100,000 and to reduce asthma hospitalizations for ages <5 to no more than 250 per 100,000 and for ages 5-64 to no more than 77 per 100,000.[5,6,7]

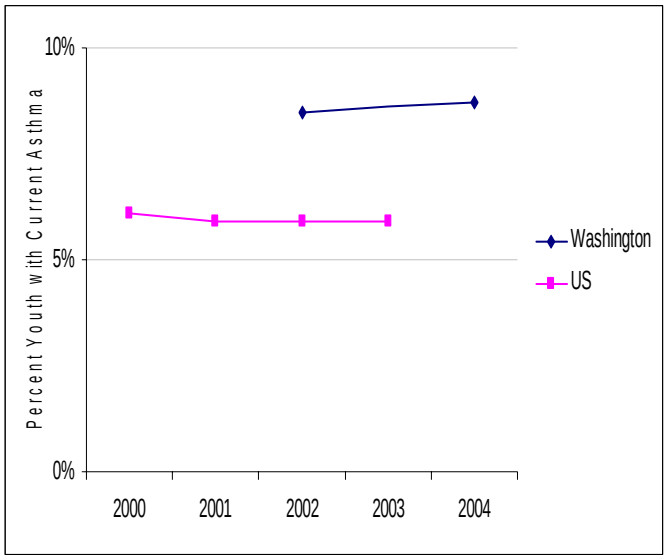
The following figures were taken directly from the Washington State Department of Health report "The Burden of Asthma in Washington State" available at: www.alaw.org/pdfs/wai/BurdenofAsthmaWASt-2005FINAL.pdf

Prevalence of current asthma among Washington children and youth (parent/adult proxy-reported)[1]



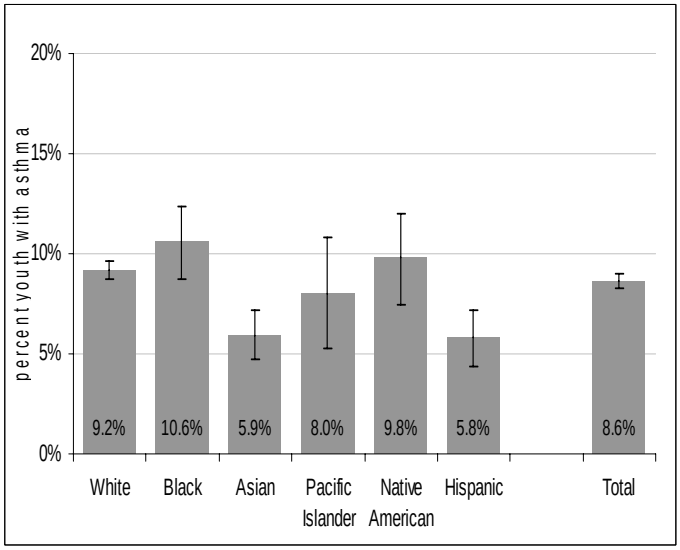
Source: 1999 and 2000 combined Behavioral Risk Factor Surveillance System, parent (proxy) reports for child asthma prevalence

Trends for current asthma among Washington State and US youth[1]



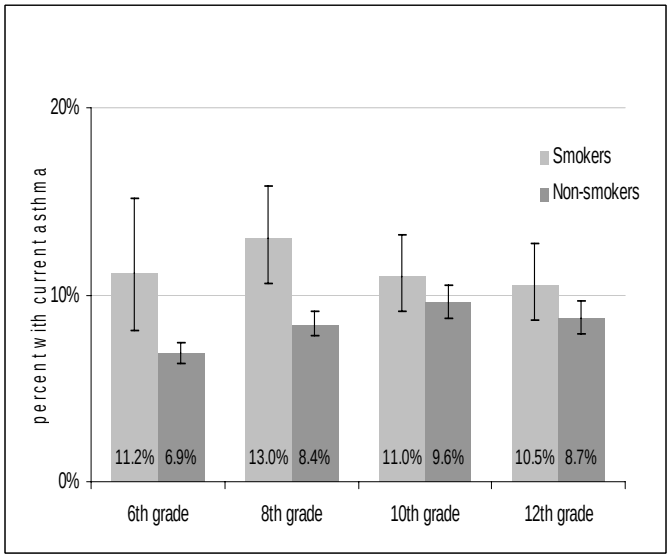
Source: 2002 and 2004 Washington State Healthy Youth Survey, grade-standardized estimate for 6th-12th grades combined; 2000-2003 National Health Interview Survey, youth aged 12-17 combined.

Prevalence of asthma by race/ethnicity, among Washington youth[1]



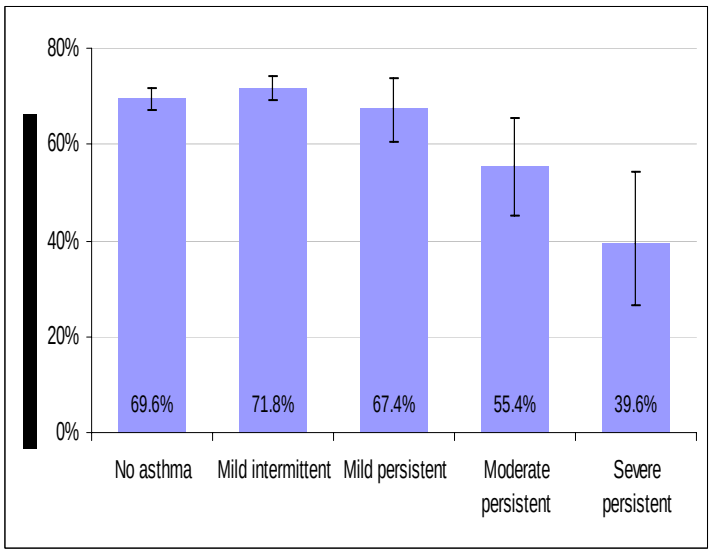
Source: combined 2002 and 2004 Washington State Healthy Youth Survey (HYS), 6-8-10-12th grade-standardized. Race and Hispanic ethnicity collected as part of a single question

Asthma Prevalence by cigarette smoking status among Washington youth[1]



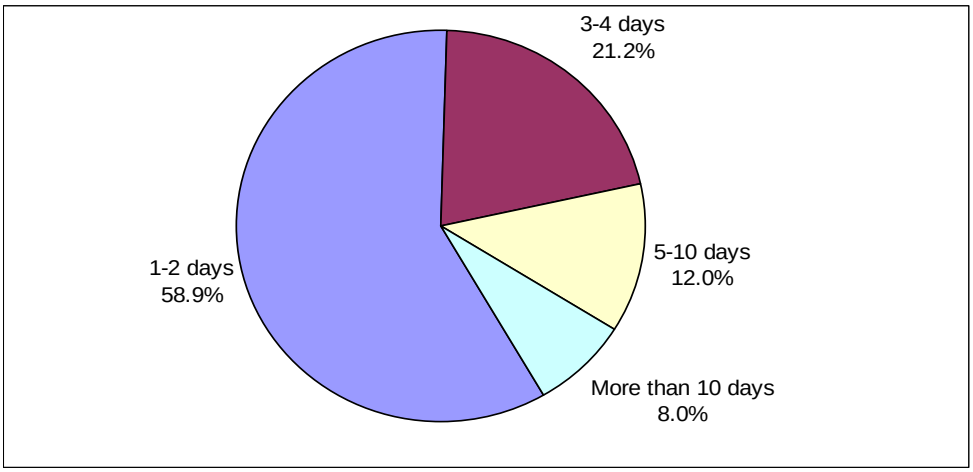
Source: 2002 and 2004 combined, Washington State Healthy Youth Survey (HYS)

Prevalence of high academic performance by asthma status and symptom severity, among Washington youth (10th grade) [1]



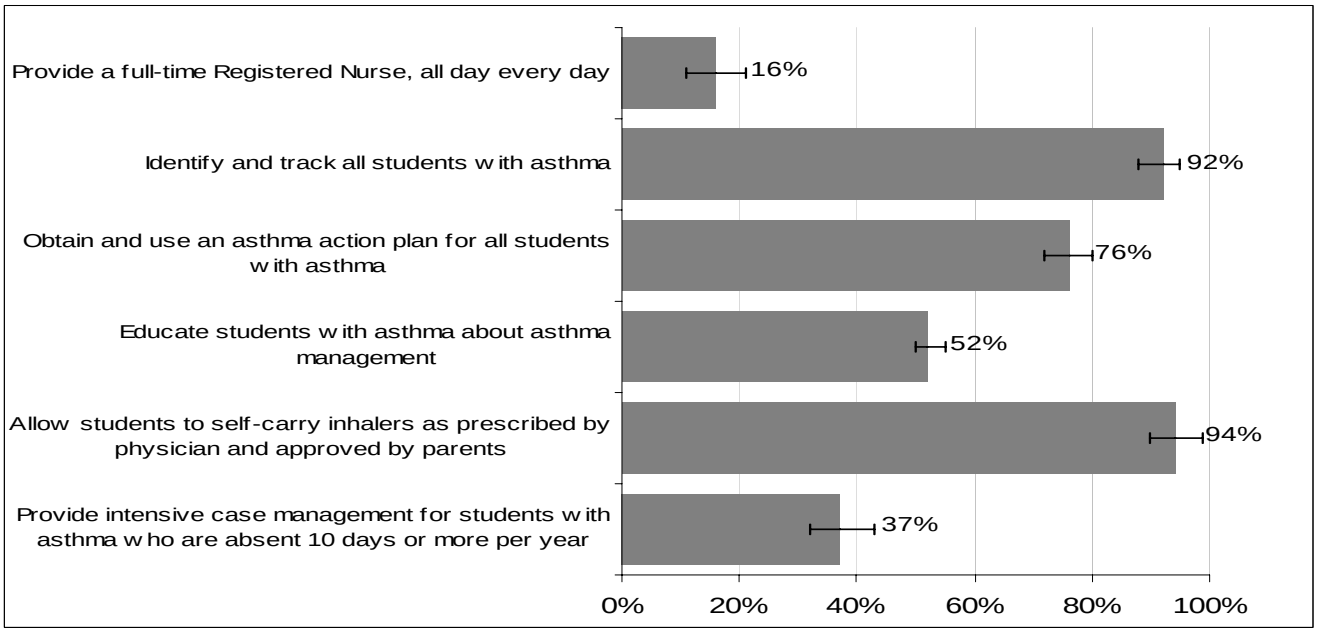
Source: 2002 and 2004 combined Washington State Healthy Youth Survey (HYS).

Distribution of days Washington youth missed school during the previous year because of asthma, among youth with asthma who missed any school days[1]



Source: 2004 Washington State Healthy Youth Survey (HYS), grades 8-10-12 combined
The percentage of children with asthma who miss school varies by grade: 38.3% in grade 8, 29.7% in grade 10, and 24.1% in Grade 12. Overall, the percentage is 31.6%.

Prevalence of asthma-related policies and practices, among Washington State secondary schools[1]



Source: 2004 Washington State School Health Education Profile (SHEP). [Note: Percentages are of schools, not students.]

Data Sources

1. Dilley JA, Pizacani BA, Macdonald SC, Bardin J. The Burden of Asthma in Washington State. Washington State Department of Health. Olympia, WA. June 2005. DOH Pub No. 345-201.
2. Washington State Behavioral Risk Factor Surveillance system (BRFSS), Washington State Department of Health, 1999-2000. Last accessed 4/30/05. Available at: http://www.doh.wa.gov/ehsphl/chs/chs-data/brfss/BRFSS_tables.htm
3. Washington State Healthy Youth Survey, 2002 and 2004.
4. Comprehensive Hospital Abstract Reporting System (CHARS), Washington State Department of Health, 1990-2004.
5. Analysis Software: Public Health – Seattle & King County, Epidemiology, Planning & Evaluation, Software for Public Health Assessment (VistaPHw), 1991 –
6. Death Certificate Data: Washington State Department of Health, Center for Health Statistics,
7. Healthy People 2010: Understanding and Improving Health, US Department of Health and Human Services, Washington DC US Government Printing Office, 2000.

Child Mortality

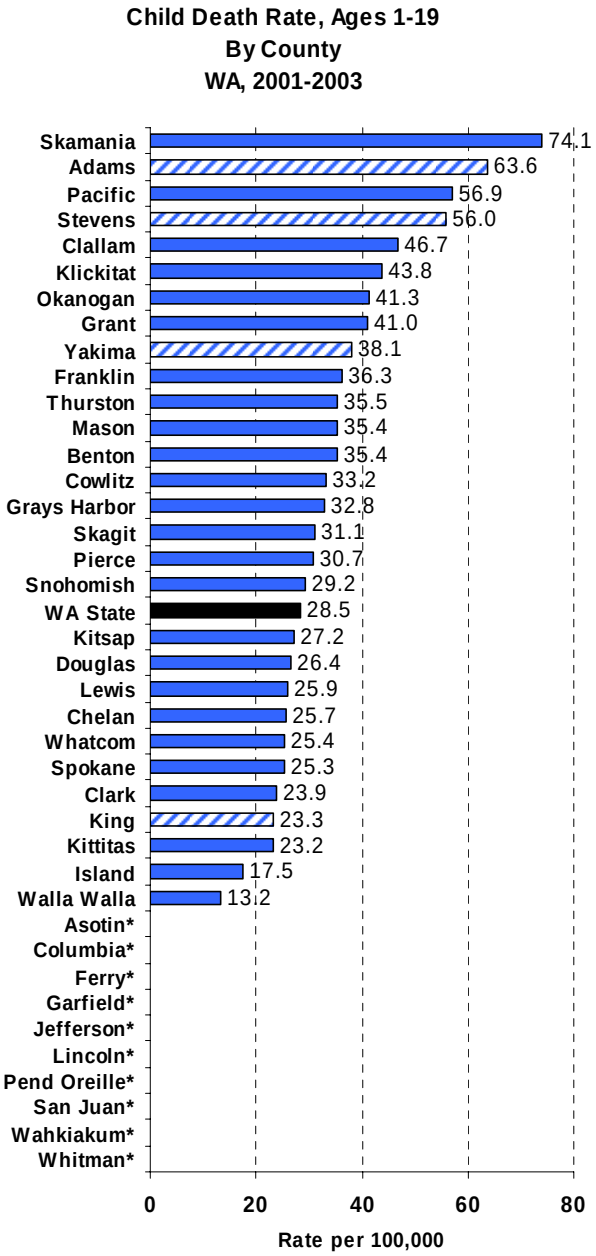
Publicly funded services to address Child Mortality are described in Immunization Program CHILD Profile, Early and Periodic Screening, Diagnosis and Treatment, Care Coordination Services, Mental Health Services, and School-Based Health Centers. In addition, the DOH Injury Program addresses unintentional and intentional injuries.

Key Findings:

- There were 454 deaths to children ages 1-19 in Washington State in 2003. Unintentional injuries accounted for 41% of the deaths, followed by suicide and homicide (18%), malignant neoplasms (11%), and congenital malformations (5%).[1,2]
- Child death rates in Washington have decreased significantly over time: from 56.8 per 100,000 children ages 1-19 in 1980 to 28.1 per 100,000 in 2003. This mirrors a national trend.[1]
- Death rates and causes differ substantially by the child's age. The highest death rates for Washington state children are in children ages 15-19 and children ages 1-4. Unintentional injuries are the leading cause of death for all Washington children ages 1-19, followed by malignant neoplasms for children ages 1-14, and suicides for children ages 10-19.[1,4]
- Child death rates are higher for male children, and children who are American Indian/Alaska Native or Black. Small town/rural areas have higher child mortality rates than other areas in the state.[1]
- The Healthy People 2010 goals for child mortality are no more than 18.6 deaths per 100,000 for ages 1-4, <=12.3 for ages 5-9, <=16.8 for children ages 10-14, and <=39.8 for ages 15-19. Washington has only met the HP 2010 child mortality goal for 10-14 year olds.[5]

Definition: Child mortality is the death of a child ages 1 through 19. This age range is chosen because it is the same as the national performance measure from the Maternal and Child Health Bureau.

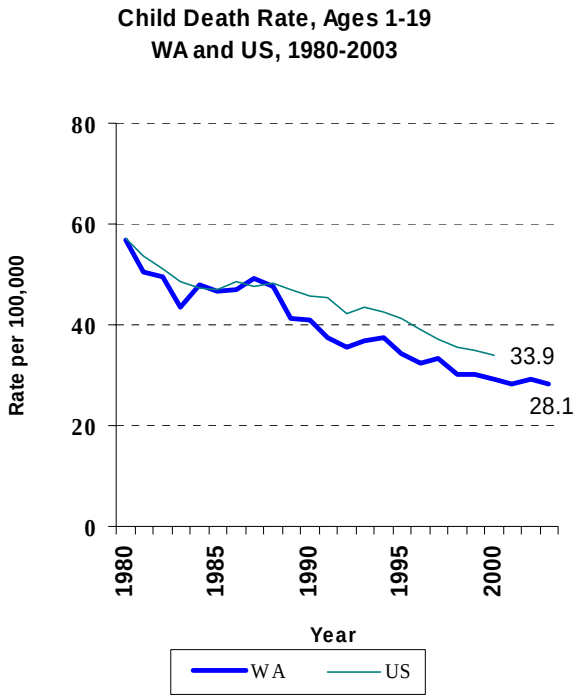
County [1,a*]



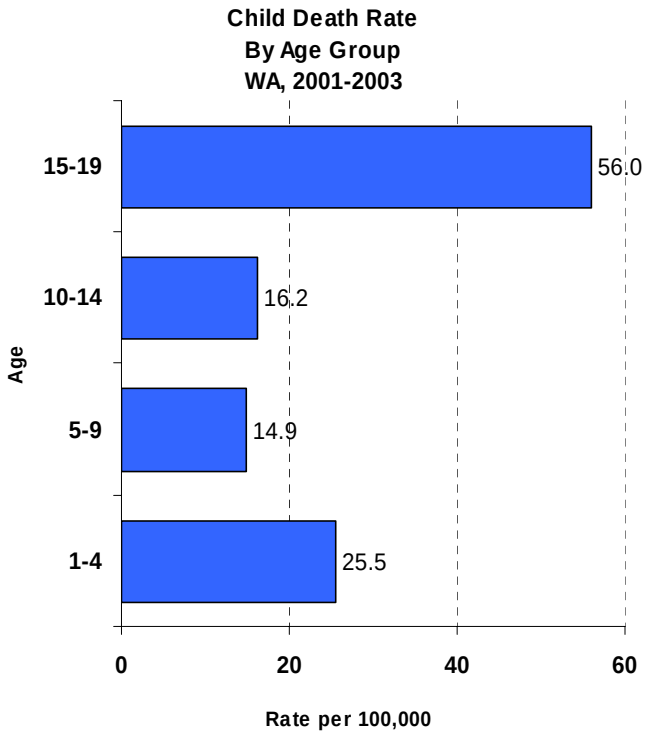
** County rate not calculated if fewer than 5 events*

Significantly different from state based on 95% confidence intervals

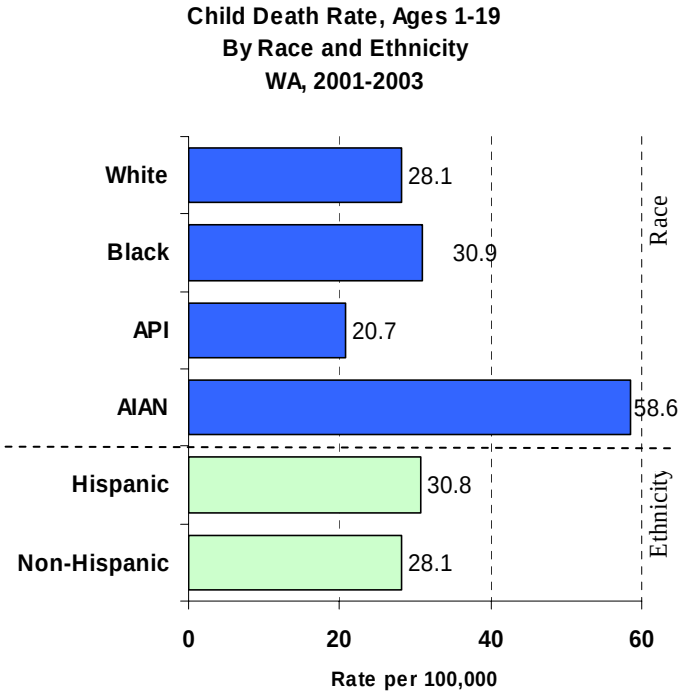
Time Trend [1,6]



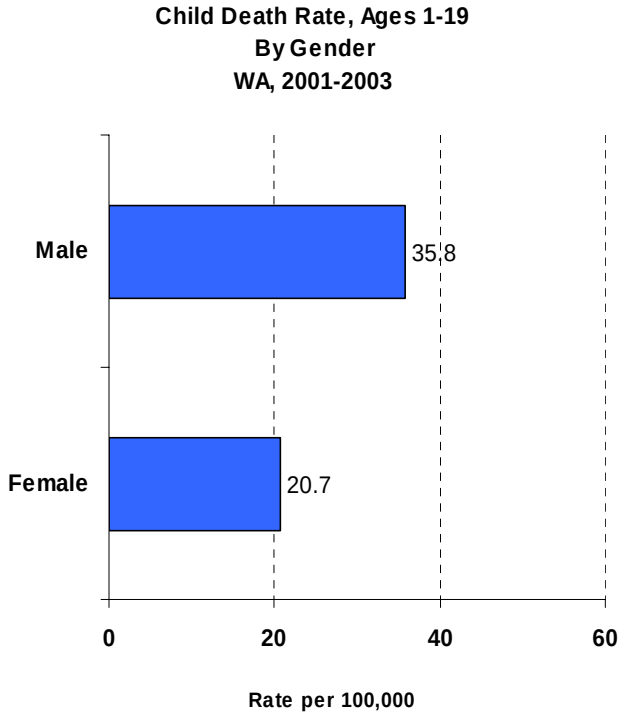
Age [1]



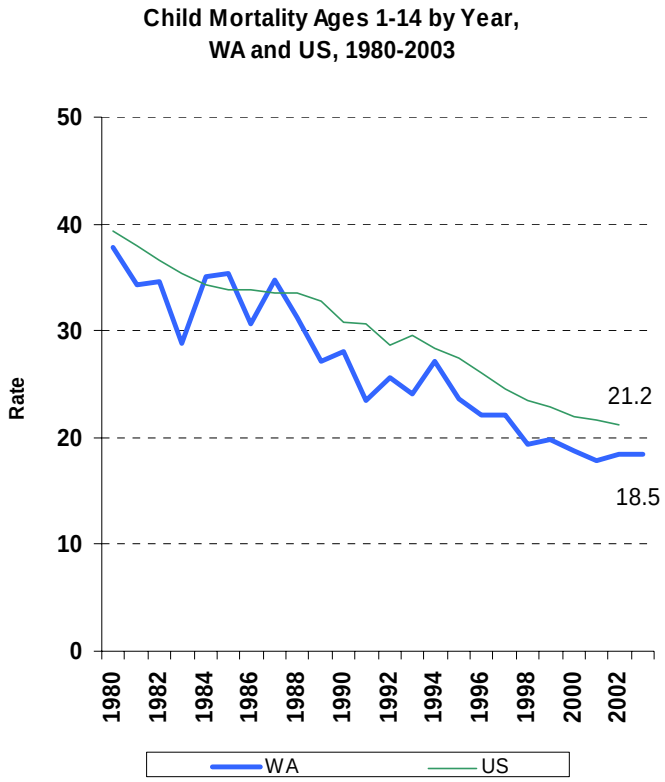
Race and Ethnicity [1,b,c]



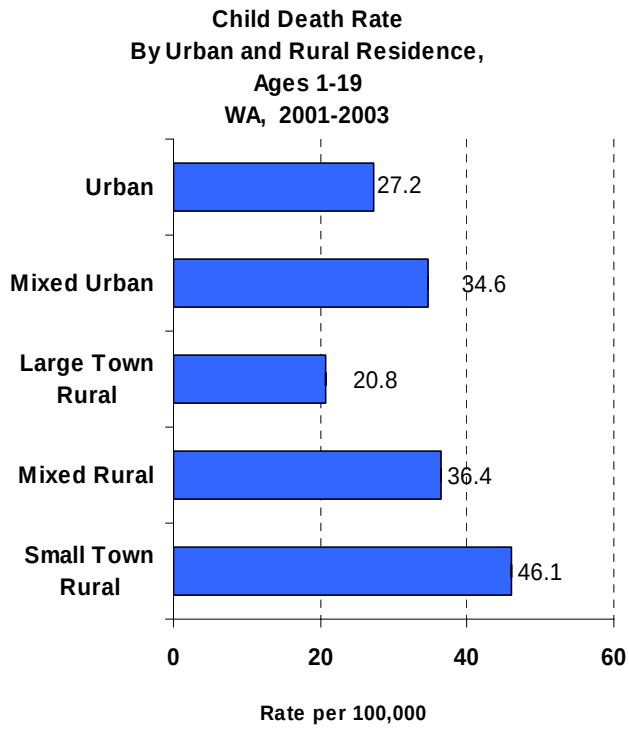
Gender [1]



Block Grant Outcome Measure:
Child death rate per 100,000 children ages 1-14 years [1,6]



Rural and Urban Residence [7,d]



Leading Causes of Child Mortality, 2000-2002
By Age Group [4]

Rank	1 - 4	5 - 9	10 - 14	15 - 19
1st	Unintentional Injury	Unintentional Injury	Unintentional Injury	Unintentional Injury
2nd	Malignant Neoplasms	Malignant Neoplasms	Malignant Neoplasms	Suicide
3rd	Congenital Anomalies	Congenital Anomalies	Suicide	Homicide

Data Sources

1. Washington State death certificate data: Vital Statistics 2003, Washington State Department of Health, Center for Health Statistics, March 2005.
2. Analysis Software: Public Health – Seattle & King County, Epidemiology, Planning & Evaluation, Software for Public Health Assessment (Vista PHw), 1991-.
3. Injury Prevention and Safety Program, Washington State Department of Health: http://www.doh.wa.gov/cfh/injury/
4. National Center for Health Statistics (NCHS), National Vital Statistics System, Centers for Disease Control and Prevention, WISQARS, "10 Leading Causes of Death, United States". May 2005
5. Department of Health and Human Services (US). Healthy People 2010: Understanding and Improving health. 2nd edition. Washington, DC: US Government Printing Office; November 2000.
6. CDC Wonder, Child death rate per 100,000 children aged 1-14 years
7. Washington State Department of Health, Office of Community and Rural Health, November 2005.

Endnotes

a. Significance was determined based on 95% Confidence Intervals
b. AIAN – American Indian/Alaska Native
c. API – Asian Pacific Islander
d. Rural urban differences are based on county level RUCA codes calculated using 2000 census data (see Technical Notes for description of RUCA codes)

Child Weight and Physical Activity

Publicly funded services to address Child Weight and Physical Activity are described in Immunization Program CHILD Profile, Nutrition Services, Early and Periodic Screening, Diagnosis and Treatment, and School-Based Health Centers. In addition, the STEPS to a Healthier Washington Program addresses child weight and physical activity.

Definition: Children are considered overweight if they are in the top 5% for Body Mass Index (BMI) by age and gender based on growth charts developed by the Centers for Disease Control and Prevention (2004). Students are considered at risk for being overweight if they are in the top 15% but not in the top 5%.

Key Findings:

- In 2004, about 10% of Washington 8th, 10th, and 12th graders were overweight based on self-reported height and weight. Nationally, the percentage of children and adolescents who are defined as overweight has more than doubled since the early 1970s. In 2003, about 13-15% of US children and adolescents were at risk for being overweight, and about 12% were overweight.[2,3]

- Older students are less likely to engage in vigorous cardiovascular exercise. In Washington, approximately 77% of students in Grades 8, 70% in Grade 10, and about 61% of students in Grade 12 engaged in vigorous physical activity (at least 20 minutes 3 or more days a week). The Healthy People 2010 target is for 85% of adolescents to engage in vigorous physical activity.[1,2]

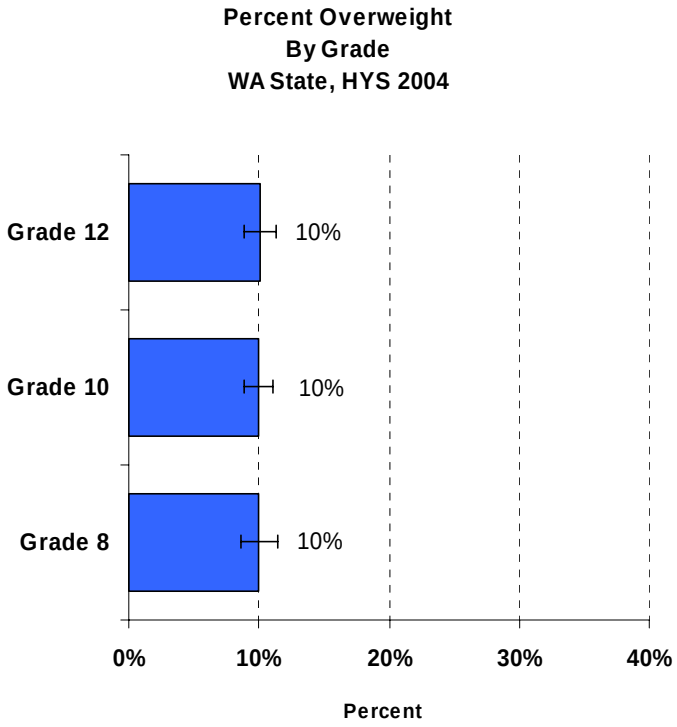
- In Washington, older students are more likely to report that they did not attend a physical education class in an average week. About 30% of 8th graders did not attend a physical education class in an average week compared to about 62% of 12th graders.[1,2]

- Generally, boys are more likely than girls to engage in daily vigorous physical activity. For instance, among 10th graders, about 74% of boys meet the recommendations for physical activity, as compared to about 66% of girls.[2]

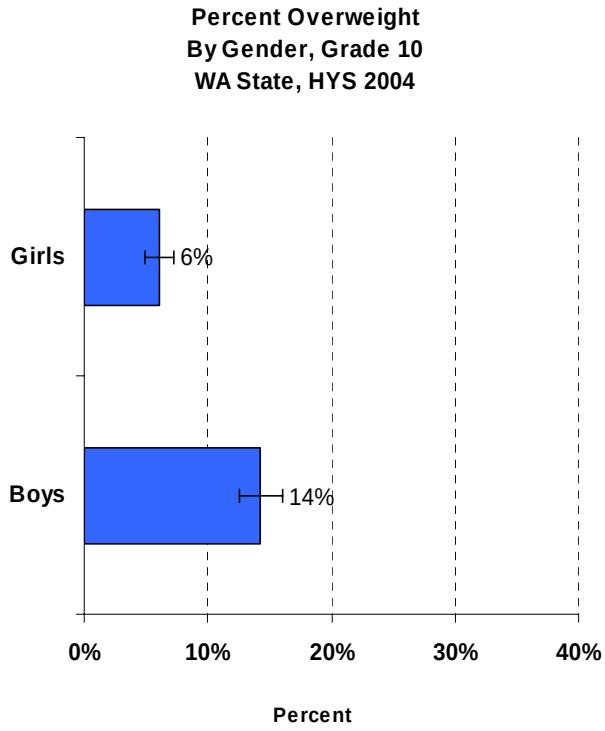
- Approximately 20% of Washington State 8th, 10th, and 12th graders reported drinking 2 or more sodas the previous day. Students who regularly eat dinner with their family are more likely to eat fruits and vegetables 5 times or more a day, and are less likely to have had two or more sodas on the previous day (Data not shown).[2]

- Students who watch television three or more hours a day during school days were about twice as likely to be overweight as students who watch television two or less hours a day. The Healthy People 2010 objective is to increase the proportion of adolescents who view television two or fewer hours on a school day to 75%.[1,2]

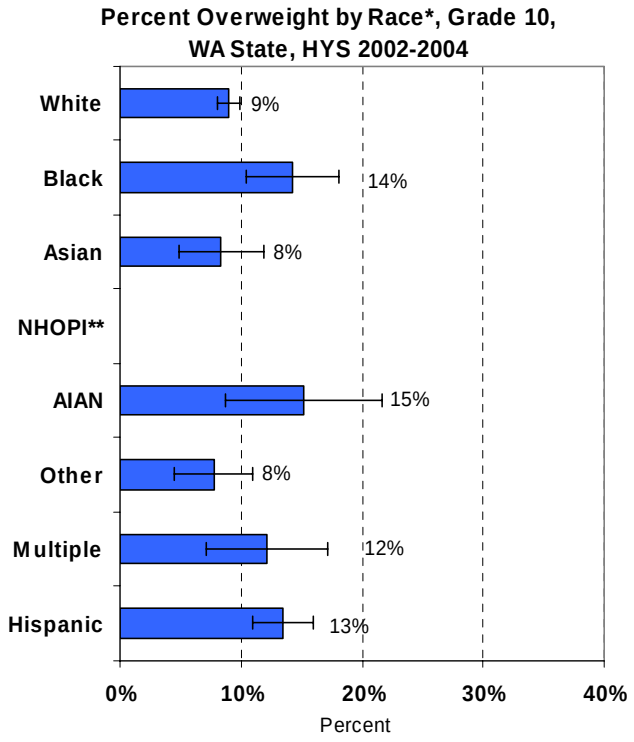
Grade [2]



Gender [2]



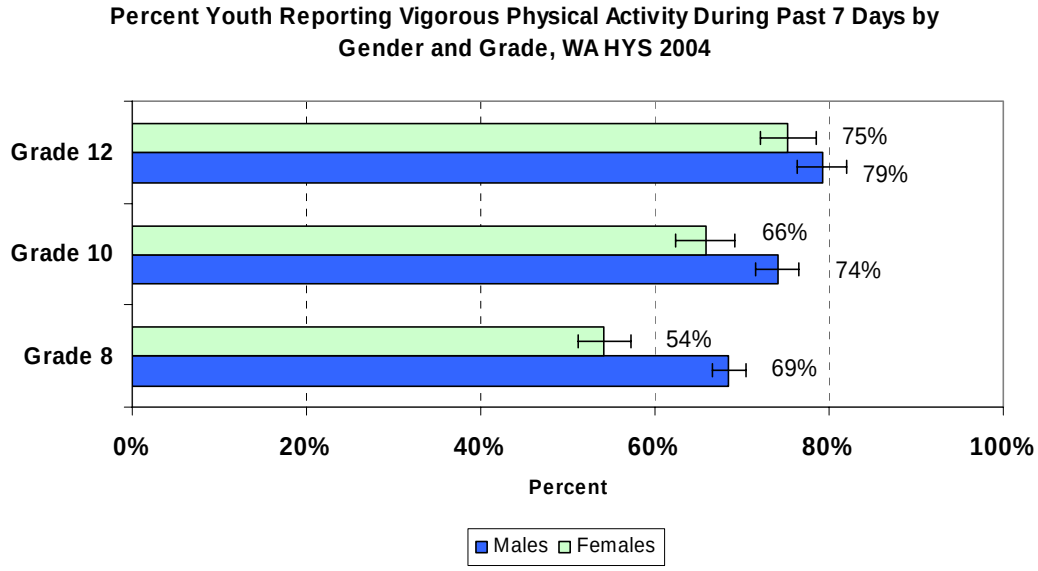
Race and Ethnicity [2,a,b]



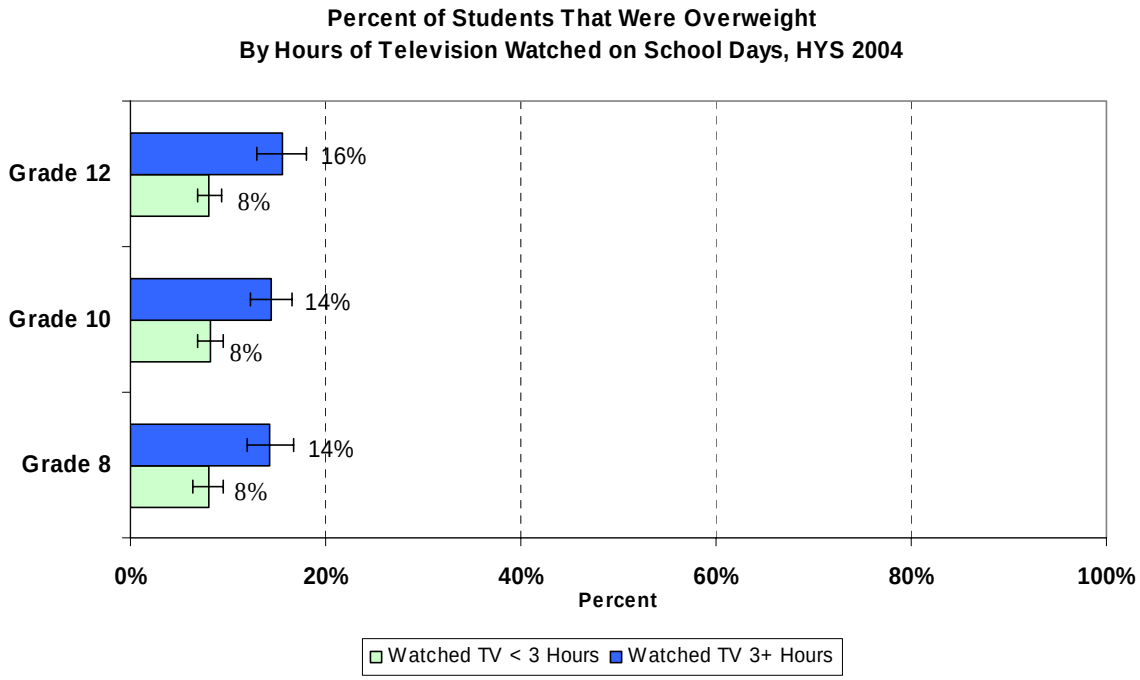
**In the Healthy Youth survey, Hispanic ethnicity is asked in the same question as race. Students are asked to choose one or more races, including Hispanic ethnicity, as appropriate.*

***Rates have been suppressed where n<15*

Vigorous Physical Activity [2]



Television Watching [2]



The percentage of children who watch three or more hours of television per day varies by grade: 32.3% in grade 8, 29.0% in grade 10, and 23.7% in grade 12. Overall, the percentage is 28.8%.

Data Sources

1. Department of Health and Human Services (US). Healthy People 2010: Understanding and Improving Health. 2nd edition. Washington, DC: US Government Printing Office; November 2000.
2. Washington State Healthy Youth Survey 2002 and 2004. Washington State Office of Superintendent of Public Instruction, Department of Health, Department of Social and Health Services, and Department of Community, Trade, and Economic Development and RMC Research Corporation. Online website: http://www3.doh.wa.gov/HYS/ASPX/HYSQuery.aspx
3. Department of Health and Human Services, Center for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. Youth Risk Behavior Surveillance System (YRBSS). Website: http://www.cdc.gov/HealthyYouth/yrbs/index.htm. 2003

Endnotes

a. NHOPI – Native Hawaiian or Pacific Islander
b. AIAN – American Indian/Alaska Native

Family Violence

Publicly funded services to address Family Violence are described in Emergency/Temporary Housing, Juvenile Rehabilitation Services, and School-Based Health Centers. In addition, the DOH Injury Program addresses Family Violence.

Key Findings:

- Family violence, which includes child abuse and intimate partner violence, is prevalent, but is often difficult to measure. In this section, a variety of data sources are relied upon.
- Abuse can include physical, psychological, sexual, and economic abuse.
- While existing data are helpful in understanding the prevalence of abuse, more data are needed to understand health disparities.

Child Abuse

Child Protective Services

- Only a portion of child abuse is reported to Child Protective Services (CPS). In 2004, there were 45,326 accepted referrals to Washington CPS for child abuse and neglect in Washington.[1]

History of Child Abuse

- Females are over twice as likely as males to report a history of childhood sexual abuse. In 2004, about 20% of Washington women (ages 18 and over) and 8% of men reported a history of sexual abuse as a child. Males and females have an approximately equal likelihood to report childhood physical abuse. About 12% of men and 10% of women reported physical abuse as a child.[2]
- In 2002, about 16-18% of Washington youth in 8th, 10th, and 12th grades reported being physically abused by an adult at some point in their lives.[3]

Family Violence: Violence or abuse of any type, perpetrated by one family member against another family member. Includes both child abuse and intimate partner violence.

Intimate Partner Violence

Crime in Washington

- In 2004, 39,025 domestic violence offenses (including 61 homicides) were reported in Washington State. This accounted for about 10% of all crimes reported in the state not counting the additional 13,025 reported violations of protection orders.[4]
- In cases of murder and non-negligent homicide, where the relationship of victim to offender was reported, 24% were within the family.[4]
- Females were significantly more likely to report that before they were 18 years old, someone had touched them sexually place or made them touch someone sexually when they did not want to.[5]

Partner Threatened or Physically Hurt

- In 2004, about 6% of Washington 8th graders, 9% of 10th graders, and 10% of 12th graders reported a boyfriend or girlfriend had limited their activities or made them feel unsafe. (Data not shown)[3]
- In 2004, about 6-8% of Washington 8th, 10th, and 12th graders reported a boyfriend or girlfriend had hit or physically hurt them in the past 12 months. Males were more likely to report being hurt than females.[3]
- Nationally, violence against women occurs in 20% of dating couples.[6]
- Nationally, an average of 28% of high school and college students experience dating violence at some point.[7]

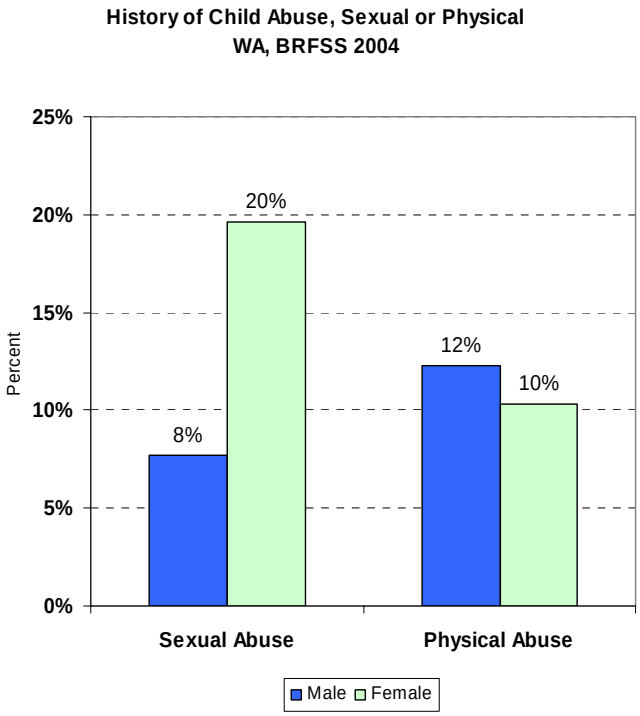
Pregnancy Violence

- In 2003, the percentage of pregnant Washington women reporting physical abuse by their husband or partner remained approximately 5% before and during pregnancy (5% before, 4% during, 4% after).[8]
- Physical abuse in Washington State before, during, and after pregnancy was more likely to be reported by younger women, Medicaid recipients, women with less than 12 years of education, and Native Americans.[8]
- In 2003, 61% of pregnant Washington women reported being asked by their provider about domestic violence during pregnancy.[8]
- Younger women, less educated women, Hispanic women and women on Medicaid were significantly more likely to report a health care worker had asked them if someone was hurting them emotionally or physically.[8]

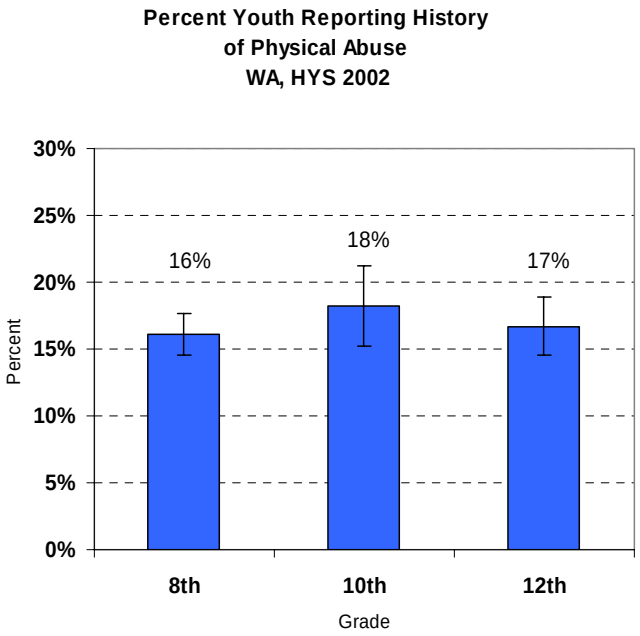
Healthy People 2010 [9]

- The Healthy People 2010 objective is to reduce the rate of physical assault by current or former intimate partners to 3.3 physical assaults per 1,000 persons ages 12 years and older.
- The Healthy People 2010 objective is to reduce maltreatment to 10.3 per 1,000 children under age 18 years, and maltreatment fatalities of children to 1.4 per 1,000 children under the age of 18 years.

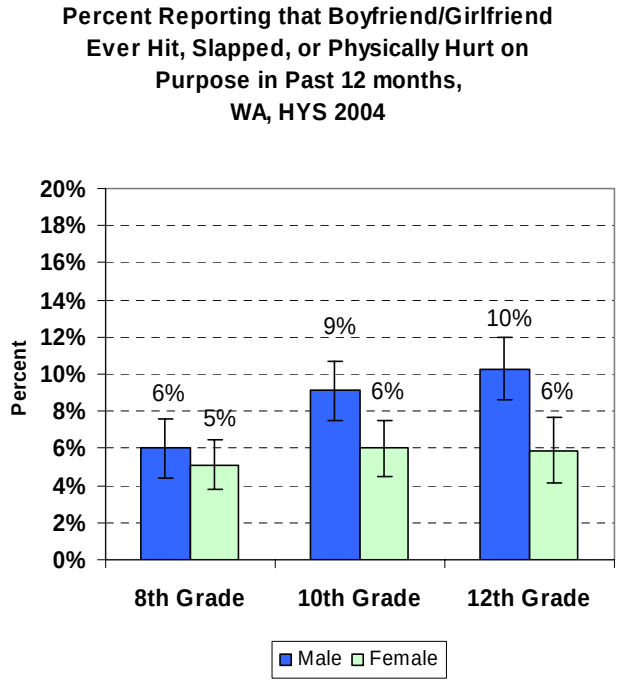
History of Child Abuse: Adult Reported [2]



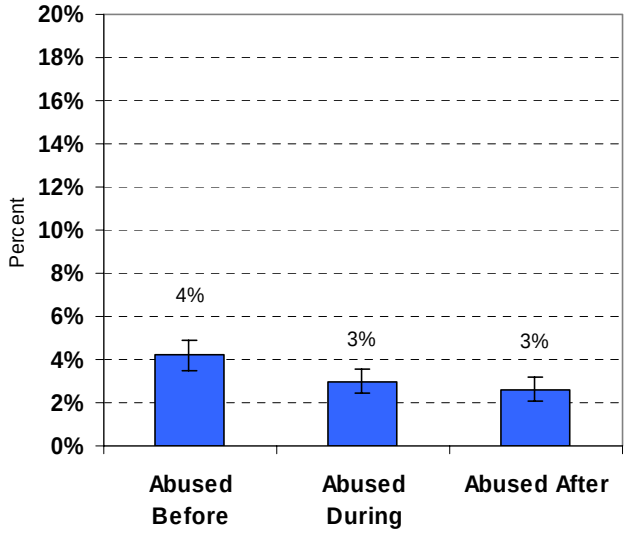
History of Child Abuse: Youth Reported [3]



Intimate Partner Violence: Youth Reported [3]

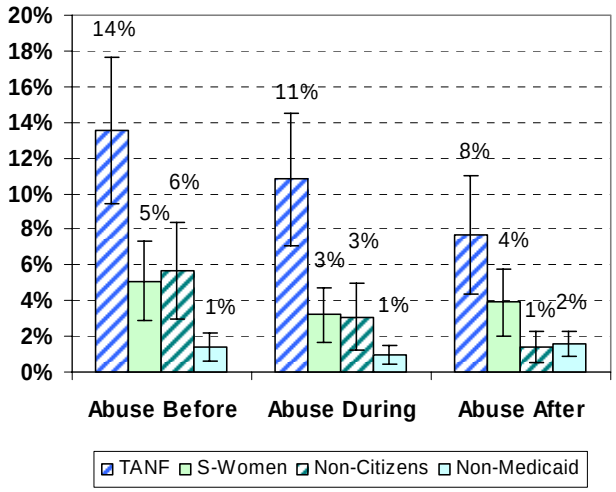


Intimate Partner Violence: Pregnant Women [8]



Intimate Partner Violence: Pregnant Women by Medicaid [8,a]

Percent of Pregnant Women Reporting Abuse by Husband, by Medicaid Status* WA, PRAMS, 2001-2003



***** Medicaid women received maternity care paid for by Medicaid. They are divided into three major subgroups (from highest to lowest socioeconomic status): **S-Women** - those women who are citizens and eligible to receive Medicaid because they are pregnant and have incomes at or below 185% FPL, **TANF** - those women who are very low income (generally < 50% FPL) and receive cash assistance (TANF) in addition to Medicaid, and **Non-Citizens** - those women who are not citizens and are eligible to receive Medicaid because they are pregnant and have incomes at or below 185% FPL. Non-citizens are not eligible for TANF although their incomes are often lower than women on TANF. All three Medicaid groups have incomes below most Non-Medicaid women.

Data Sources

1. Washington State Department of Social and Health Services, CAMIS Referral Files, April 2005.
2. Behavioral Risk Factor Surveillance System (BRFSS), Washington State Department of Health, 2004.
3. Washington State Healthy Youth Survey 2002 and 2004. Washington State Office of Superintendent of Public Instruction, Department of Health, Department of Social and Health Services, and Department of Community, Trade, and Economic Development and RMC Research Corporation.
4. Washington Association of Sheriffs and Police Chiefs: *Crime in Washington 2004 Report*, http://www.waspc.org/wucrwibr/CIW_2004.pdf
5. Behavioral Risk Factor Surveillance System (BRFSS), Washington State Department of Health, 1999-2000.
6. American Psychology Association; Violence and the Family: Report of the American Psychological Association Presidential Task Force on Violence and the Family (1996), p. 10.
7. Brustin, S., Legal Response to Teen Dating Violence, Family Law Quarterly, vol. 29, no. 2, 331 (Summer 1995) (citing Levy, In Love & In Danger: a teen's guide to breaking free of an abusive relationship, 1993).
8. Washington Pregnancy Risk Assessment Monitoring System (PRAMS), Washington State Department of Health, 2001-2003.
9. Department of Health and Human Services (US). Healthy People 2010: Understanding and Improving Health. 2nd edition. Washington, DC: US Government Printing Office; November 2000.

Endnotes

a. The source for the Medicaid designations used is the Washington State Department of Social and health Services First Steps Database.
b. Significance is based on 95% Confidence Intervals
c. AIAN – American Indian/Alaska Native
d. API – Asian or Pacific Islander

Food Insecurity and Hunger

Publicly funded services to address Food Insecurity and Hunger are described in Nutrition Services

Definition: Food insecurity is the limited or uncertain availability of nutritionally adequate and safe foods, or limited or uncertain ability to acquire acceptable foods in a socially acceptable way. Hunger is the uneasy or painful sensation caused by a lack of food, and the recurrent and involuntary lack of access to food.

Key Findings:

- According to data from the Washington State Population Survey, over the period of 2002-2004, an estimated 11% of Washington's households were food insecure, and an estimated 5% of households were food insecure with hunger, compared to about 11% of US households that were food insecure, and 4% that were food insecure with hunger.[1]

- As of November 2004, Washington State ranked 10th highest in the nation for food insecurity with hunger. This is a dramatic improvement from the past (5th from 2000-2002, and 2nd in 1999-2001).[2,3]

- In Washington, having a low income, being a Non-White race and having children has been strongly associated with food insecurity and hunger. (Data not shown) [4]

- Based on 1995-1999 survey data from the Behavioral Risk Factor Surveillance System (BRFSS) Washington women ages 18-44 reported that in the 30 days before the survey, about 7% were concerned about having enough food, 5% skipped meals because there was not enough money to buy food, and 2% went without food for an entire day. More recent data is currently unavailable at the state level. (Data not shown) [5]

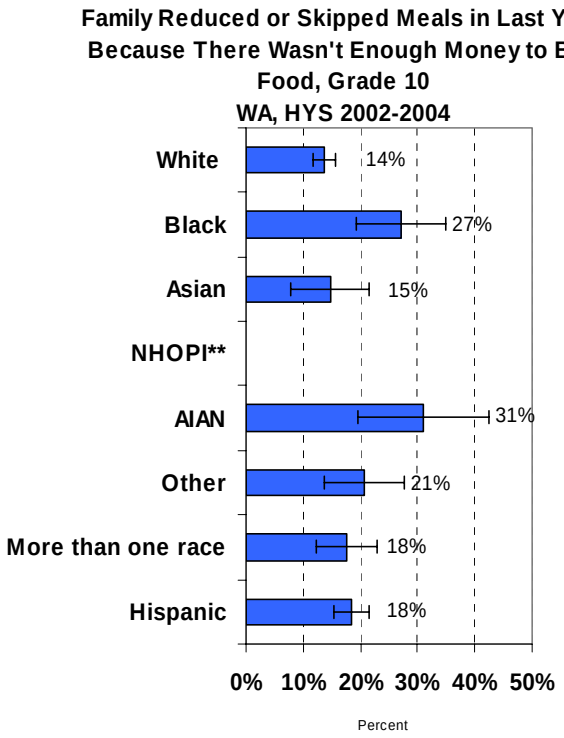
- Data are not available on the food security of young children. However, some data on adolescents are available. In the 2004 Washington Healthy Youth Survey, about 15% of 10th grade students reported that their family had reduced or skipped meals in the last 12 months because there was not enough money to buy food.[4]

- Based on 2002-2004 Washington data from the Healthy Youth Survey, Black and American Indian/Alaska Native 10th graders were significantly more likely to report that their family had skipped or reduced meals in the past year due to lack of money than other races.[4]

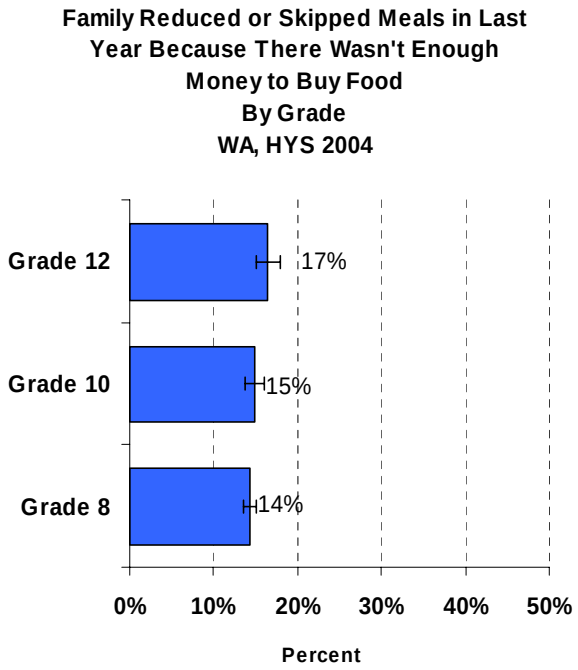
- Health effects of hunger and food insecurity in children are associated with having more psychosocial problems, frequent colds, ear infections, anemia, asthma, and frequent headaches.[3,6,7]

- The Healthy People 2010 objective is to increase the prevalence of food security among US households to at least 94 percent of all households. Washington has not yet met this objective.[8]

Race and Ethnicity [3,a,b]



Grade [3]



**In the Healthy Youth Survey, Hispanic ethnicity is asked in the same question as race. Students are asked to choose one or more races, including Hispanic ethnicity, as appropriate.*
*** Rates have been suppressed where n<15*

Data Sources

1. Washington State Population Survey 2004. Office of Financial Management. Website: http://www.ofm.wa.gov. Accessed 2005.
2. Healthy Mothers Healthy Babies Coalition of Washington State. Website: http://www.hmhbwa.org/forprof/education/hunger_food.htm. Accessed 10/05.
3. Sullivan, A., Choi, E. Hunger and Food Insecurity in the Fifty States: 1998-2000. Food Security Institute, Center on Hunger and Poverty, Heller School for Social Policy and Management, Brandeis University. August 2002. (Updated articles found at: http://www.financeprojectinfo.org/WIN/food_security.asp)
4. Washington State Healthy Youth Survey 2002 and 2004: Online Version. Washington State Office of Superintendent of Public Instruction, Department of Health, Department of Social and Health Services, and Department of Community, Trade, and Economic Development and RMC Research Corporation.
5. Behavioral Risk Factor Surveillance System (BRFSS), Washington State Department of Health, 1995-1999.
6. Prevalence of Food Insecurity and Hunger, by State, 1996-1998. Food and Rural Economics Division, Economic Research Service, US Department of Agriculture. Food Assistance and Nutrition Research Report No. 2, Sept 1999. (Updated articles found at: http://www.financeprojectinfo.org/WIN/food_security.asp)
7. National Health and Nutrition Examination Survey (NHANES). 2001-2002 Data Release. Website: http://www.cdc.gov/nchs/data/nhanes/nhanes_01_02/fsq_b_frq.pdf. Released October 2004.
8. Department of Health and Human Services (US). Healthy People 2010: Understanding and Improving Health. 2nd edition. Washington, D.C: US Government Printing Office; November 2000.

Endnotes

a. NHOPI – Native Hawaiian or Pacific Islander
b. AIAN – American Indian/Alaska Native

Immunizations/ Vaccine Preventable Diseases

Publicly funded services to address Immunizations are described in Immunization Program CHILD Profile, and Early and Periodic Screening, Diagnosis and Treatment

Key Findings:

- In 2004, about 78% of children 19-35 months of age in Washington State received all recommended immunizations (4:3:1:3:3). This is statistically comparable to the 2004 national rate of 81%.[1,b]

- In 2004, estimated immunization coverage rates for children entering kindergarten or first grade (school entry-level) included: DTaP/Td: 92%, Polio: 92%, Measles: 95%, Mumps: 96%, Rubella: 96%, and Hep B: 94%.[1]

- Underimmunization can occur when needed vaccines are not administered during acute or chronic care medical visits and when multiple vaccines are not given during the same visit. Transportation problems, lack of immunization schedule at home, multiple family moves, multiple providers, and objections to some immunizations may also serve as barriers to adequate immunization. The 4th DTaP, recommended to be administered between 15 and 23 months, is the most frequently missed immunization.[1,3]

Definition: The standard measure of appropriate immunization for two-year olds is a series of vaccinations that includes 4 doses of diphtheria, tetanus, pertussis (DTP or DTaP), 3 doses polio, 1 dose measles, mumps and rubella (MMR), 3 doses haemophilus influenzae type b (Hib) and 3 doses Hepatitis B (4:3:1:3:3). This measure has fluctuated over time.[a]

- Washington is one of about 20 states that permit immunization exemptions for school admittance due to personal or philosophical reasons. In 2004, the statewide exemption rate for children in Washington schools was approximately 4%. Over 95% of those exemptions were for personal or philosophical reasons. Other exemptions are for medical and religious reasons.[1,2]

- As the following graphs show, although cases are rare and rates low, outbreaks of other vaccine-preventable diseases still occur, emphasizing the importance of continued immunization.

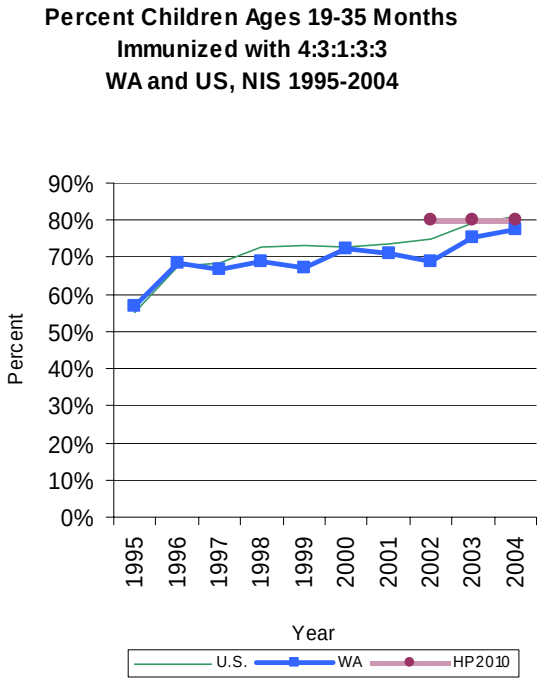
- The last diphtheria case seen in Washington was in 1979. There have been no recent wild type (non-vaccine related) polio cases in Washington and the last vaccine-related case was in 1993. In Washington State, there have been three cases of tetanus in recent years in 1997, 2000 and 2005.

- Pertussis rates in Washington are high and there have been several years since 1995 when the rates exceeded 7 per 100,000. In 2004, Washington's pertussis incidence rate (13.7/100,000) was the 12th highest in the US and the number of cases was more than four and a half times the number reported in 2001.[2,3]

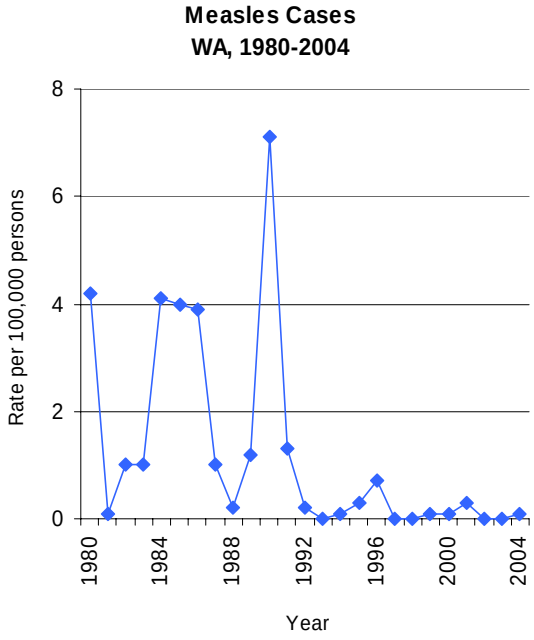
- In 2004, the NIS estimated coverage rate for varicella vaccination of children 19-35 months of age in Washington State was approximately 78%. The coverage rates for this vaccine for the State has risen consistently since 1996 when it was about 6%, but has continued to remain lower than the rate for the United States as a whole which was about 88% in 2004.[1]

- Several Local Health Jurisdictions (LHJs) have conducted, or are in the process of conducting, county or other small area preschool immunization coverage surveys. These counties are Thurston, Snohomish, Grant, Grays Harbor, Spokane, Clark, King, Lincoln, Yakima, Whatcom, Benton, Franklin, and Kittitas, Pierce and Cowlitz.[2,3]

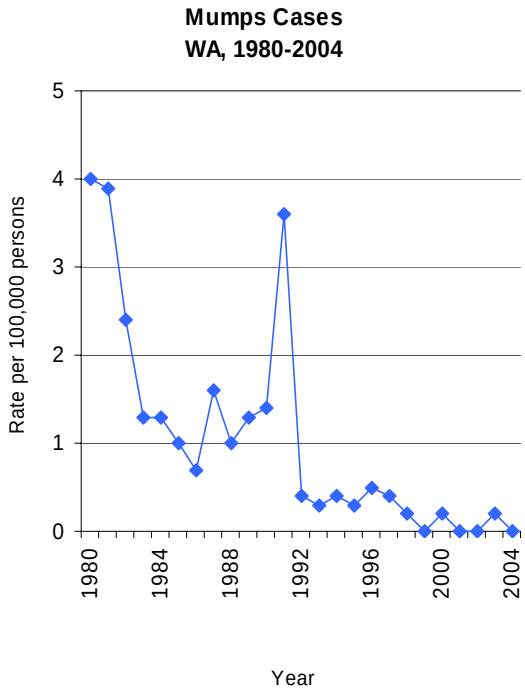
Immunization Rates [1]



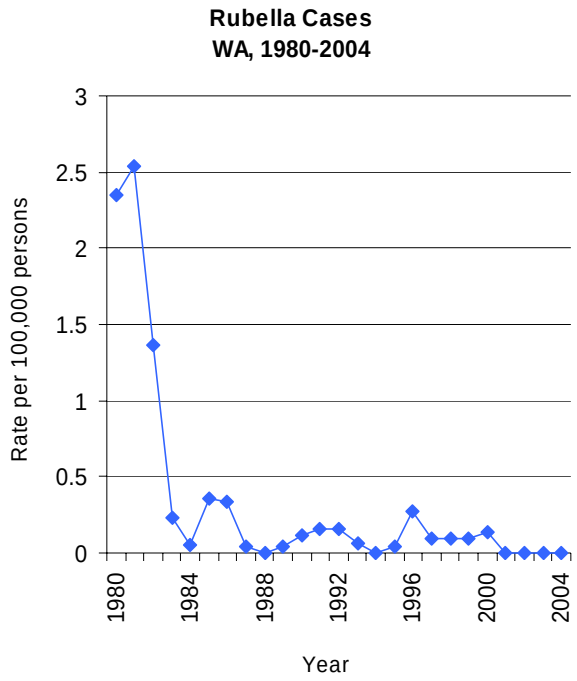
Measles Disease [3]



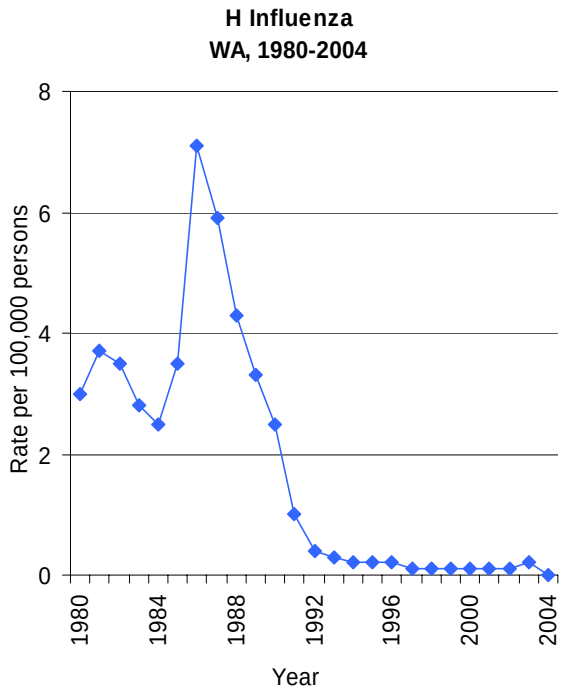
Mumps Disease [3]



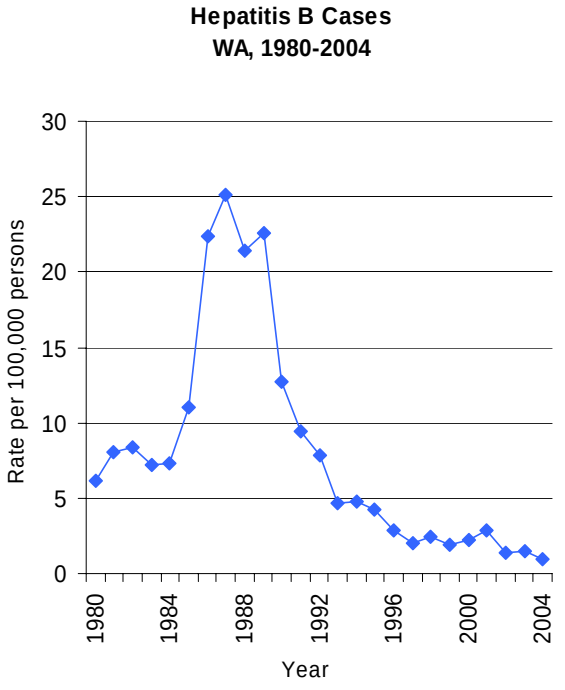
Rubella Disease [3]



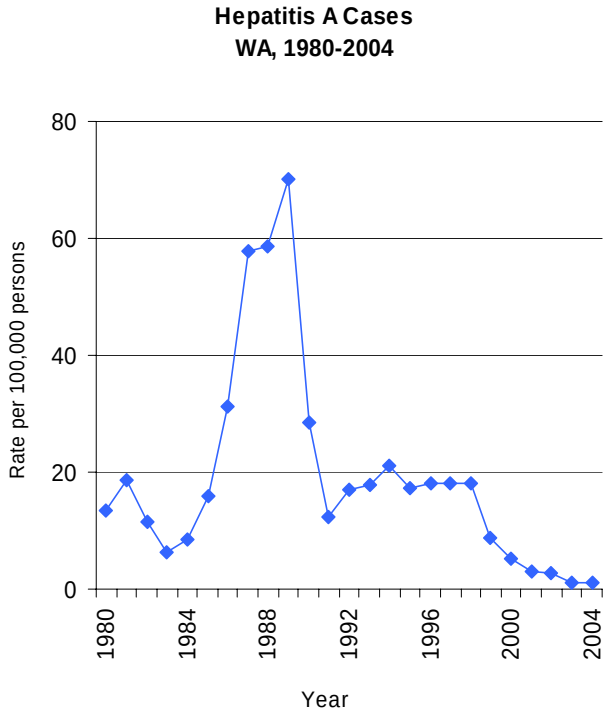
Haemophilus Influenzae Invasive Disease [3]



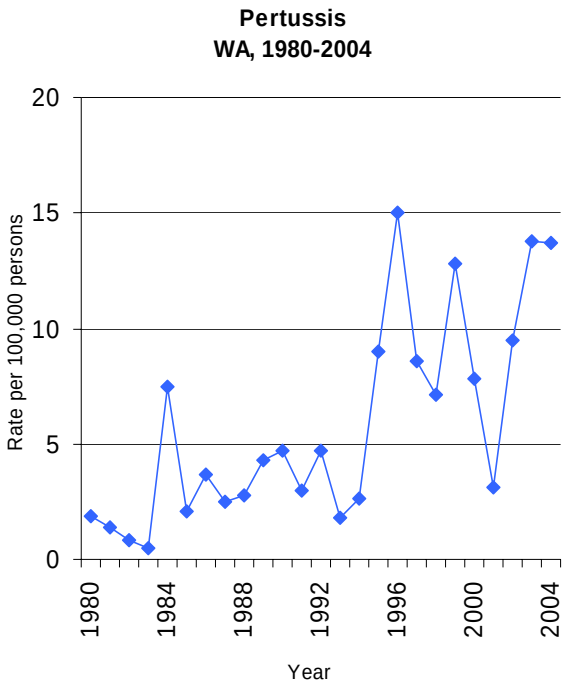
Acute Hepatitis B Disease [3]



Acute Hepatitis A Disease [3]



Pertussis Disease [3]



Data Sources

1. National Immunization Survey, Centers for Disease Control and Prevention. 2004
2. IMMENU School Data Software, Washington State Department of Health Immunization Program. 2004
3. Washington State Annual Communicable Disease Reports, Department of Health. 2004

Endnotes

a. *Abbreviations:* **DTP** - Diptheria, Tetanus and whole cell Pertussis vaccine; **DTaP** - Diptheria, Tetanus and acellular Pertussis vaccine; **DT**- Diptheria, Tetatnus vaccine (Pediatric); **Td**- Tetanus, Diptheria vaccine (Adult); **MMR**- Measles, Mumps, Rubella vaccine; **Hib**- Haemophilus influenzae type b; **HepB**- Hepatitis B; **HepA**- Hepatitis A

b. Significance is based on 95% confidence intervals

Infant Mortality

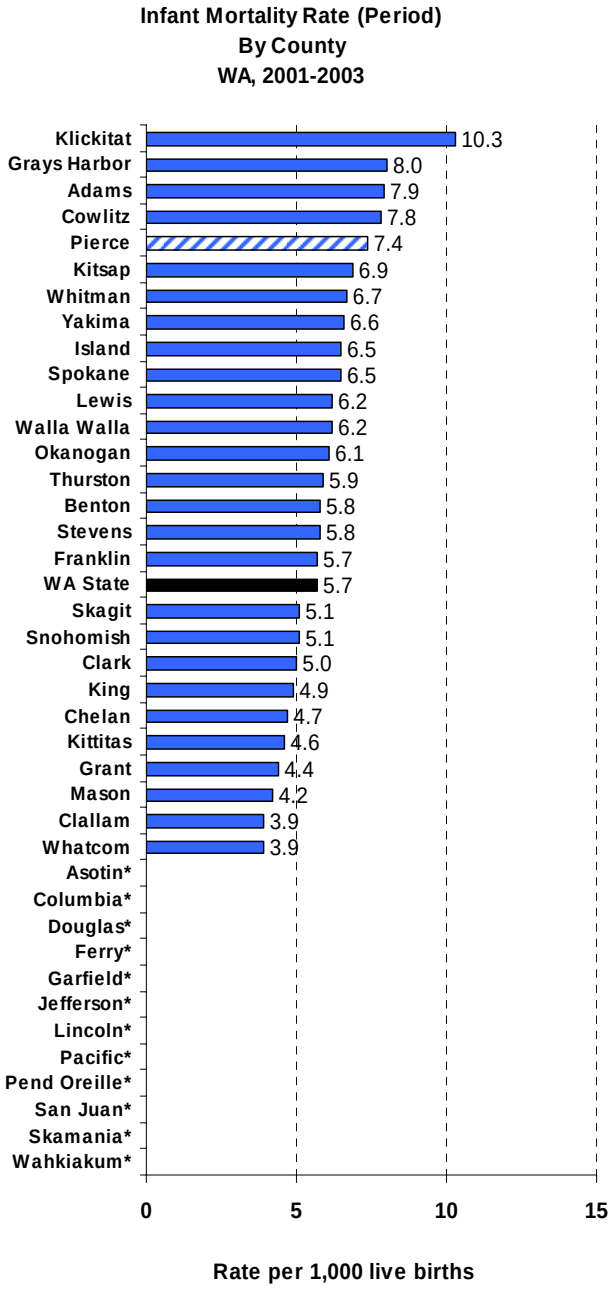
Publicly funded services to address Infant Mortality are described in First Step, Nutrition Services, Genetic Counseling, Early and Periodic Screening, Diagnostic, and Testing, and Immunization Program CHILD Profile

Key Findings:

- In 2003, 447 Washington State infants died in their first year of life. The infant mortality rate (IMR) for 2003 was 5.6 per 1,000 live births, compared to a preliminary 2003 national rate of 7.0 per 1,000 live births.[1,2,3,4]
- Washington's IMR declined significantly, from 7.8 per 1,000 live births in 1990 to 5.2 in 2000. Over the last three years, however, the infant mortality rate increased. This trend is consistent with the national pattern.[1,2,4]
- The three leading causes of infant death in Washington State in 2003 were Congenital Malformations (26.0%), Short Gestation/Low Birth Weight (13.6%), and Sudden Infant Death Syndrome (SIDS) (10.7%).[1]
- Infant mortality rates were highest for infants whose mothers were Black, American Indian/Alaska Native, or Native Hawaiian/Pacific Islander. High rates were also seen in teen mothers, mothers age forty and over, male infants, and infants whose mothers were on welfare (TANF).[1,5]
- The Healthy People 2010 objective is to reduce the infant mortality rate to no more than 4.5 per 1,000 live births. Washington has not yet met this objective.[3]

Definition: Infant mortality is the death of a child under one year of age. These deaths are often divided into two groupings: *Neonatal* mortality (death of an infant within the first 27 days of life) and *Postneonatal* mortality (death of an infant of 28-364 days of age).

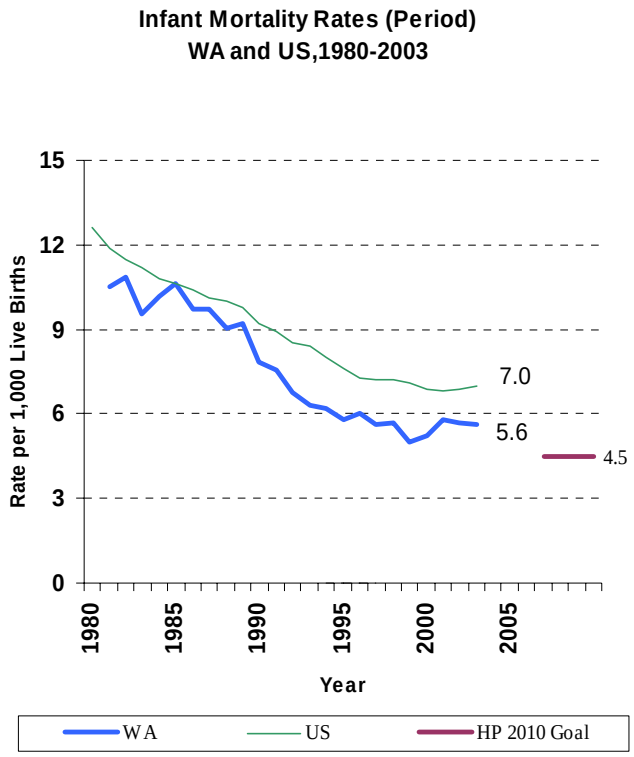
County[1,2,a,b]



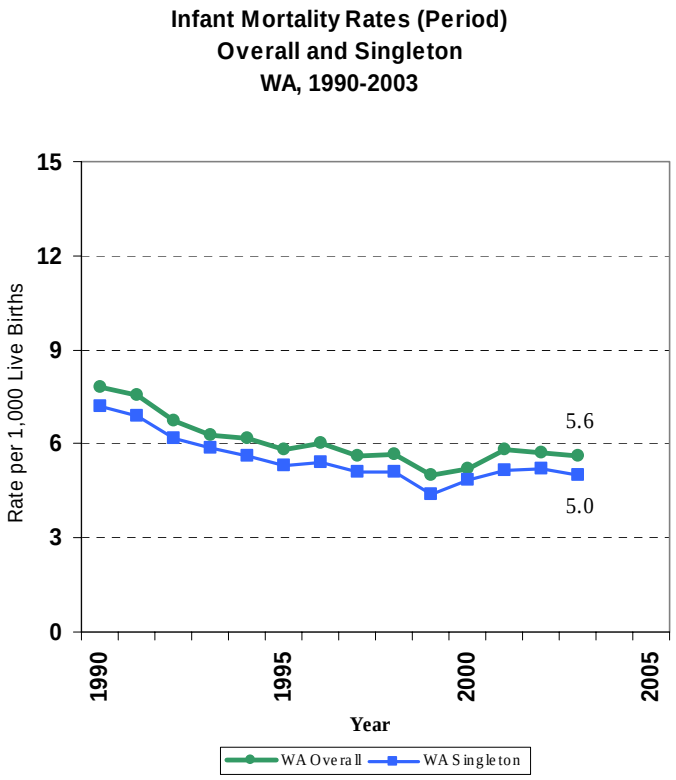
**County rates not calculated if less than 5 events*

Significantly different from state based on 95% confidence intervals

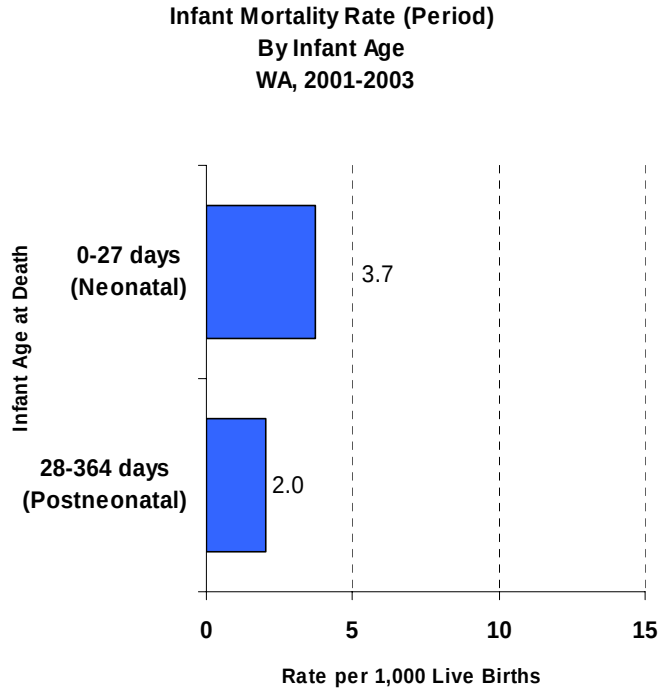
Trend [1,2,4,b]



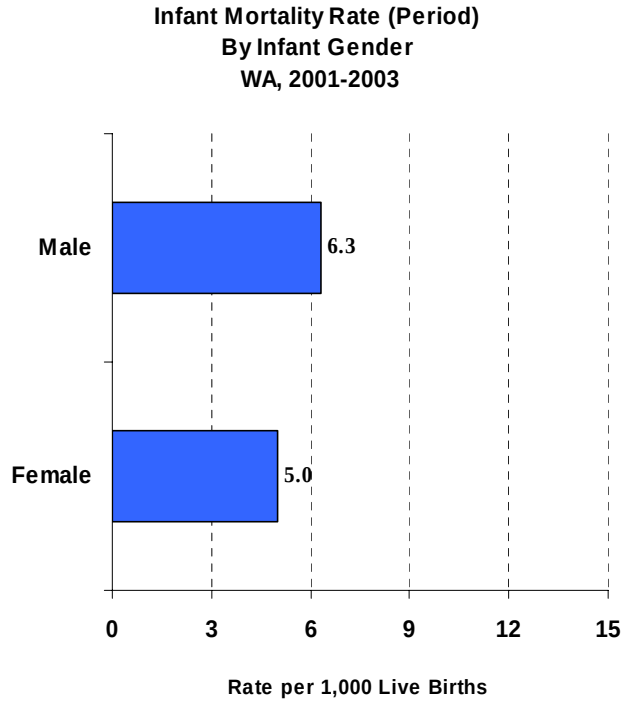
Singleton Infant Mortality [1,2,4,b]



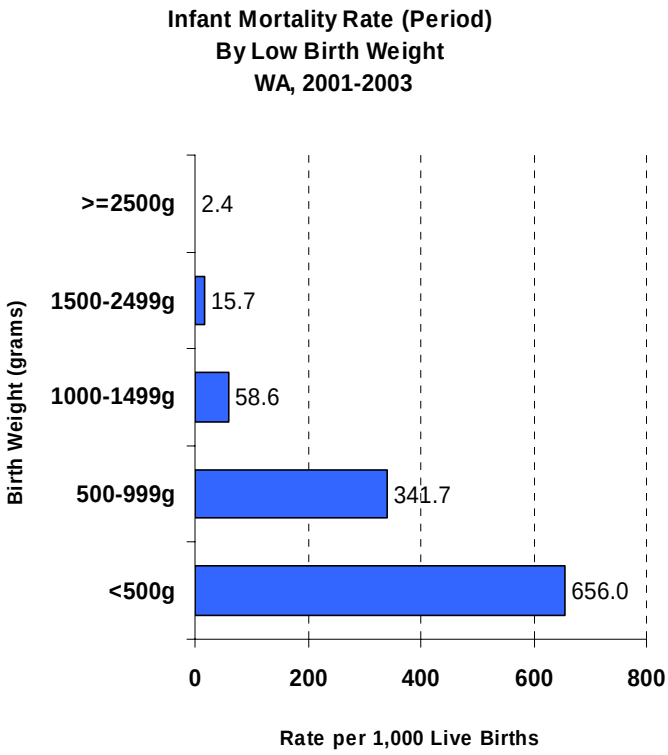
Age [1,2,b]



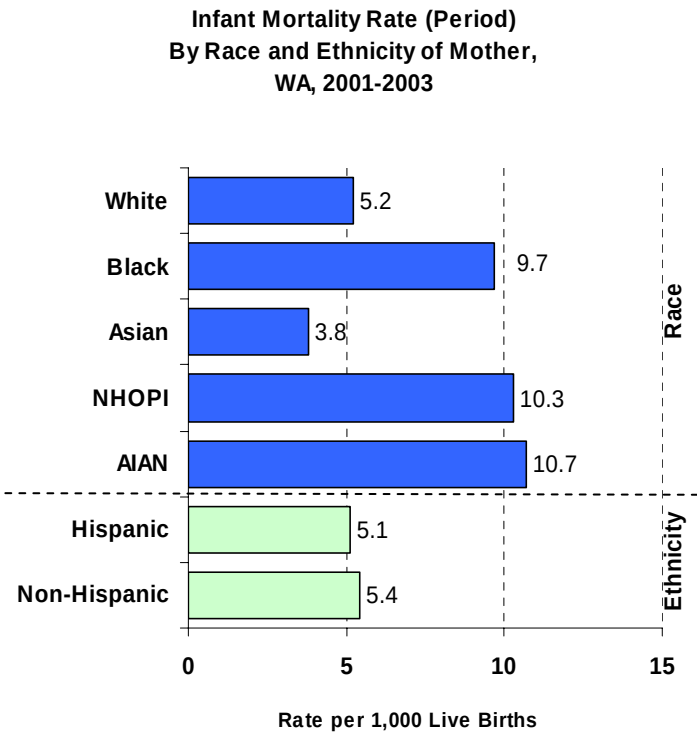
Infant Gender [1,2,b]



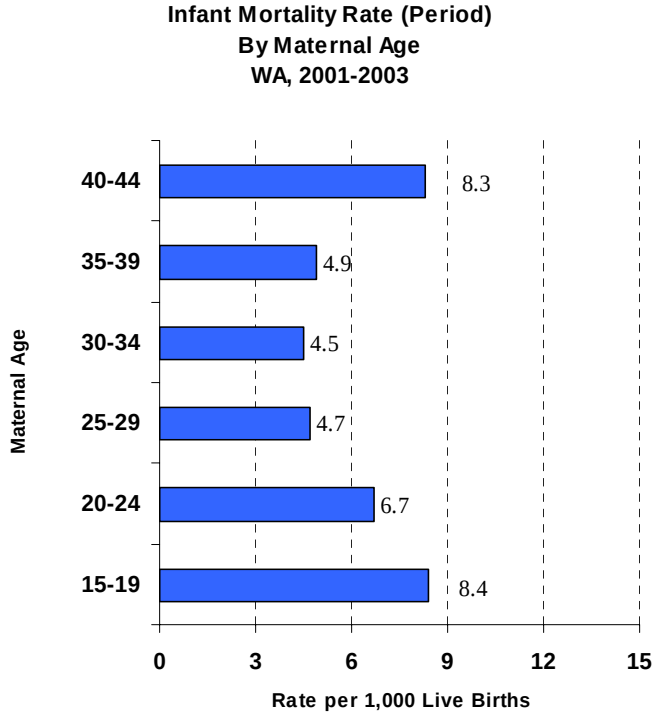
Birth Weight [1,2,b]



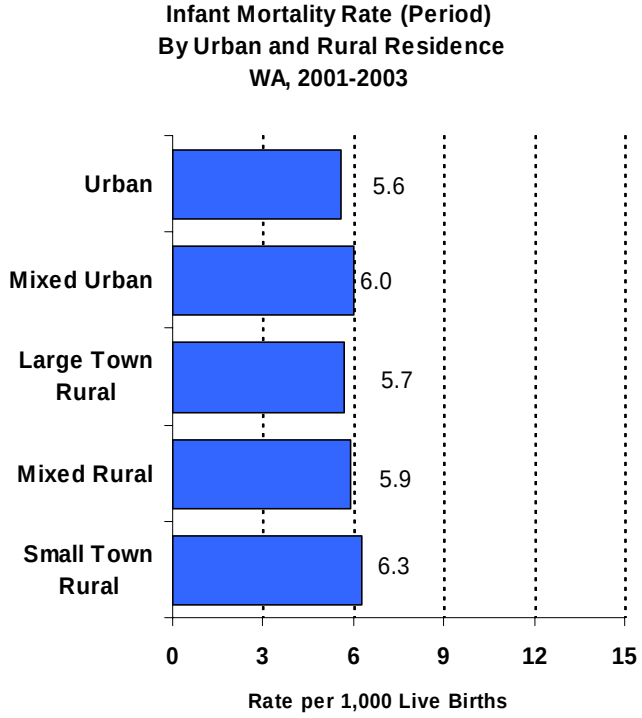
Race and Ethnicity [1,2,b,d,e,f]



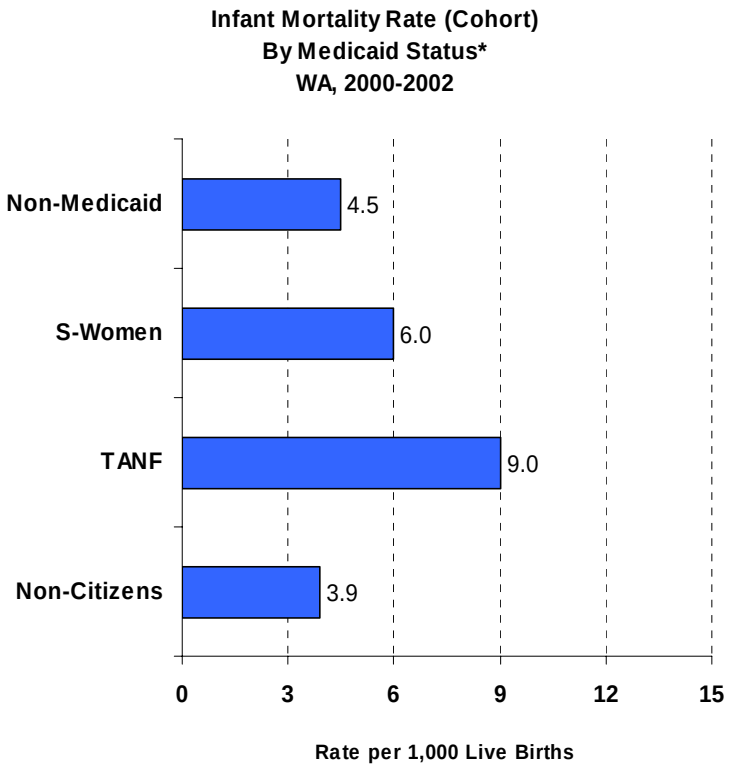
Mother's Age [1,2,b]



Rural and Urban Residence [6,b,g]



Medicaid Status [5,c]



***** Medicaid women received maternity care paid for by Medicaid. They are divided into three major subgroups (from highest to lowest socioeconomic status): **S-Women** - those women who are citizens and eligible to receive Medicaid because they are pregnant and have incomes at or below 185% FPL, **TANF** - those women who are very low income (generally < 50% FPL) and receive cash assistance (TANF) in addition to Medicaid, and **Non-Citizens** - those women who are not citizens and are eligible to receive Medicaid because they are pregnant and have incomes at or below 185% FPL. Non-citizens are not eligible for TANF although their incomes are often lower than women on TANF. All three Medicaid groups have incomes below most Non-Medicaid women.

Data Sources

1. Washington State Linked birth and death certificate data: Vital Statistics 2003, Washington State Department of Health, Center for Health Statistics, March 2005.
2. Analysis Software: Public Health – Seattle & King County, Epidemiology, Planning & Evaluation, Software for Public Health Assessment (VistaPHw), (1991-.
3. Healthy People 2010: Understanding and Improving Health, US Department of Health and Human Services, Washington DC. US Government Printing Office, 2000.
4. National Center for Health Statistics (NCHS), Vital Statistics Reports, Vol. 53, No. 15 (Preliminary 2003 Data), March 14, 2005. http://www.cdc.gov/nchs/data/nvsr/nvsr53/nvsr53_15.pdf
5. Cawthon L, Infant Mortality (Infant Deaths per 1000 live births) by Medicaid Eligibility for Births 2000-2002. Washington State Department of Social and Health Services, First Steps Database, 5/10/05.
6. Washington State Department of Health, Office of Community and Rural Health, November 2005. http://www.doh.wa.gov/hsqa/ocrh/

Endnotes

a. Significance was determined based on 95% Confidence Intervals.
b. Period Infant Mortality Rates use infant deaths in a given year as the numerator and infant births in the same year as the denominator.
c. Cohort Infant Mortality Rates look at the experience of a birth cohort. The denominator includes all births in a specified year (cohort) and the numerator is the deaths that occurred to that cohort in the first year of life.
d. In 2003 a new birth certificate form was implemented, allowing for multiple race reporting. It is not known how reporting differences may have affected infant mortality rates by race/ethnicity.
e. NHOPI – Native Hawaiian and Other Pacific Islander
f. AIAN – American Indian/Alaska Native
g. Rural urban differences are based on county level RUCA codes calculated using 2000 census data (see Technical Notes for description of RUCA codes)

Intentional Injury: Mortality and Hospitalizations

Publicly funded services to address Intentional Injury are described in Immunization Program CHILD Profile, Mental Health Services, and School-Based Health Centers. In addition, the DOH Injury Program addresses intentional injury.

Key Findings:

Mortality [b]

- In 2003, there were 86 deaths due to intentional injury for Washington state residents ages 0-19 (48 suicides and 38 homicides), resulting in an intentional injury mortality rate of 5.1 per 100,000 children ages 0-19 (or 2.8 per 100,000 for suicides, and 2.2 per 100,000 for homicides).[1,2]
- From 2001-2003, youth ages 15-19 had the highest intentional injury death rates (13.6 per 100,000) of all Washington children followed by infants (4.7 per 100,000).[1,2]
- From 2001-2003, males 0-19 had intentional injury death rates over three times greater than females. Intentional injury death rates were higher in American Indian/Alaska Native and Black children compared to other races.[1,2]
- Firearms were the most frequently used mechanism for intentional injury deaths, followed by suffocation, cutting/piercing, and poisoning.[3]
- Forty-two youth ages 15-19 committed suicide in 2003. The suicide rate for Washington youths ages 15-19 was 9.6 per 100,000, down from 12.6 per 100,000 in 1990.[1,2]

Definitions:

Intentional injury deaths: Due to homicides and suicides. [a]

Intentional injury hospitalizations: Those due to assault (ICD-9 codes E960-E969), or attempted suicide (ICD-9 codes E950-E959) as the primary E-code. The data source is the Washington State Comprehensive Hospital Abstract Reporting System (CHARS). Patients hospitalized more than once with the same diagnosis are counted as separate incidents.

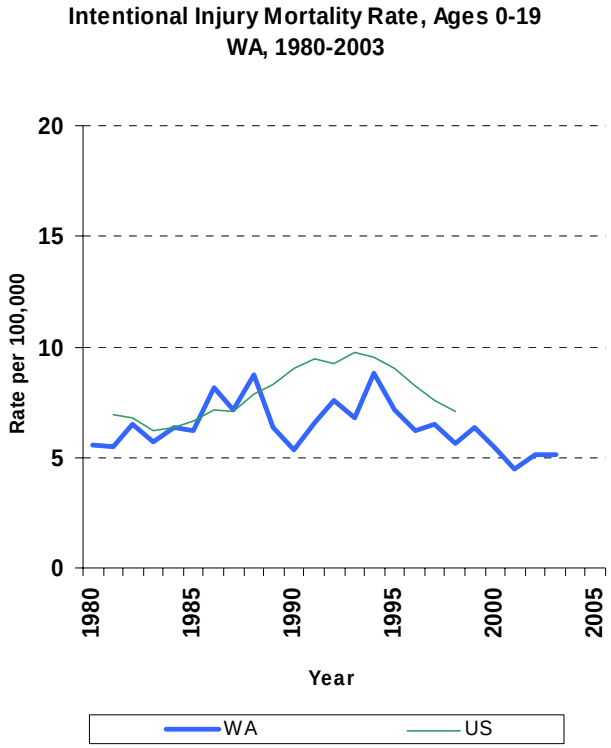
- The Healthy People 2010 goals for all ages are to reduce suicides to no more than 5.0 per 100,000 population and homicides to no more than 3.0 per 100,000.[5]

Hospitalizations

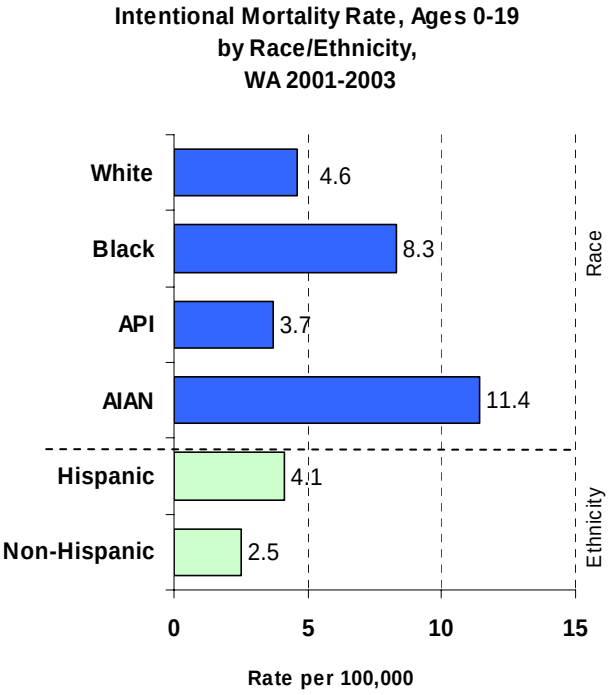
- In 2003, there were 688 nonfatal hospitalizations due to intentional injury for Washington state residents ages 0-19, for a rate of 40.6 per 100,000. This represents a 32% decline from the 1989 rate of 59.8 per 100,000.[6]
- In 2003, 370 Washington adolescents ages 15-19 (84.2 per 100,000) were hospitalized after a suicide attempt.
- The intentional injury hospitalization rates for 2001-2003 were highest in Washington children ages 15-19 years and in infants.[6]
- From 2001-2003, Washington females ages 0-19 had a significantly higher intentional injury hospitalization rate than males.[6]
- While the leading cause of intentional injury hospitalizations differ by age, for all Washington children ages 0-19 the most common causes for nonfatal intentional injury hospitalizations were poisoning, cutting/piercing, and struck by/against (which includes injuries caused by being struck by an object or person).[6]
- Urban and Mixed Urban areas have significantly higher intentional injury hospitalizations than less urban areas in the state.[7]

Mortality

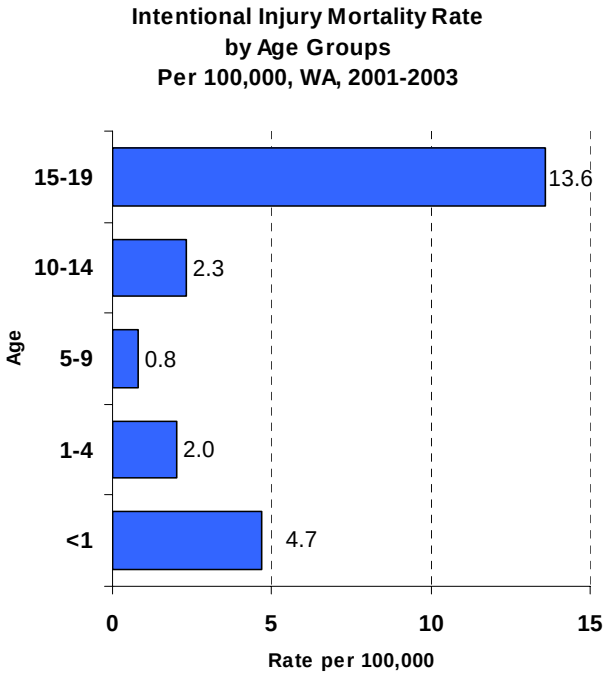
Time Trend [1,2]



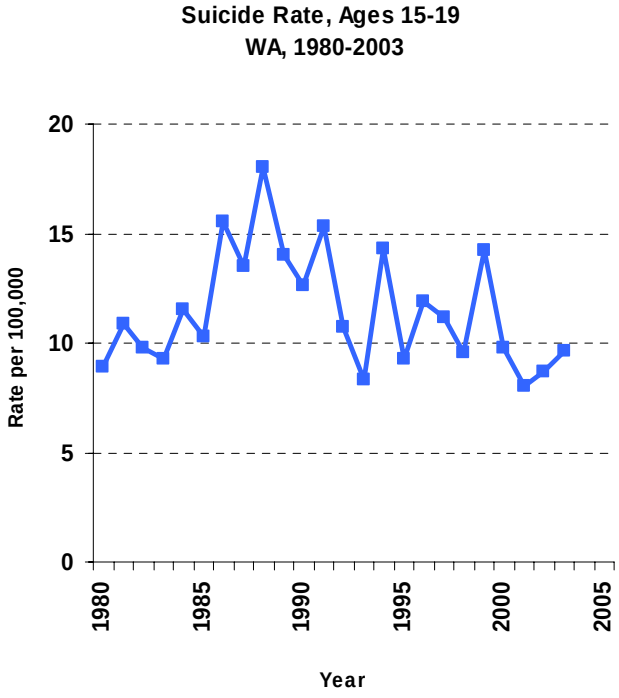
Race and Ethnicity [1,2,c,d,e]



Age [1,2]



Block Grant Measure: Suicides: 15 to 19 year olds [1,2]



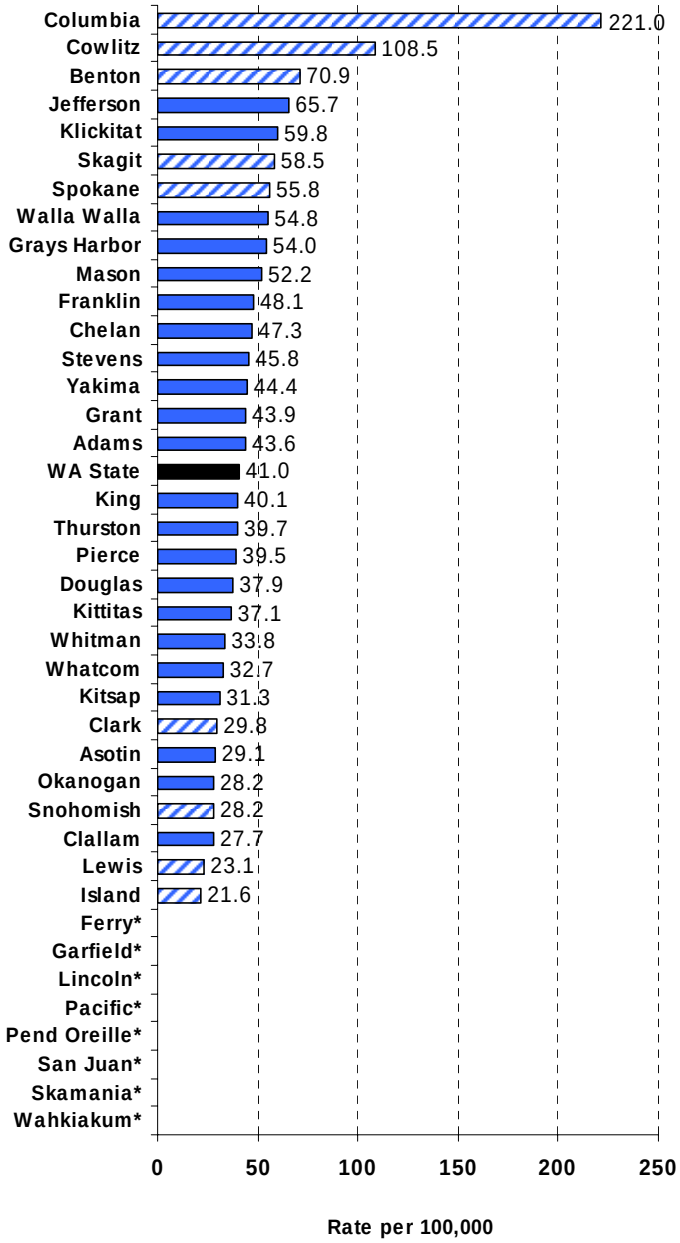
Gender [1,2]

Leading Causes of Intentional Injury Deaths WA Children, Ages 0-19, 1999-2003 [3]	
Rank	**Causes**
1st	Firearms (N=214)
2nd	Suffocation (N=82)
3rd	Cut/ Pierce (N=28)
4th	Poisoning (N=25)

Hospitalizations
(Non-Fatal Injuries) [g]

County [6,f,g]

Nonfatal Intentional Injury Hospitalization Rate By County Per 100,000, WA, 2001-2003

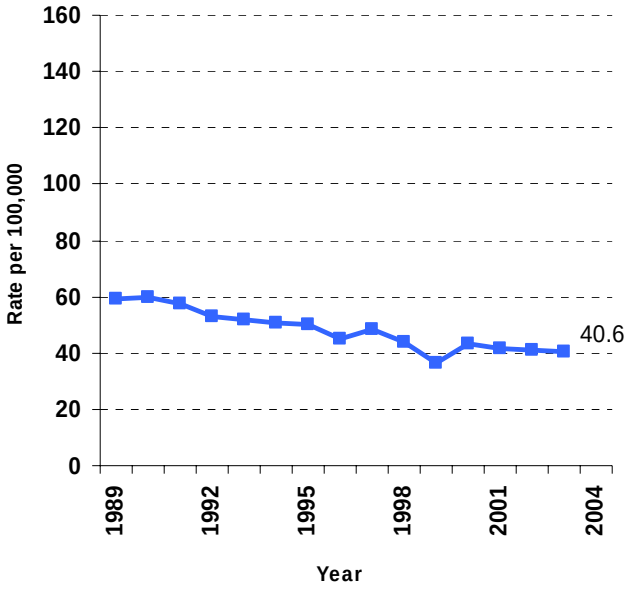


**County rates not calculated if less than 5 events*

Significantly different from state based on 95% confidence intervals

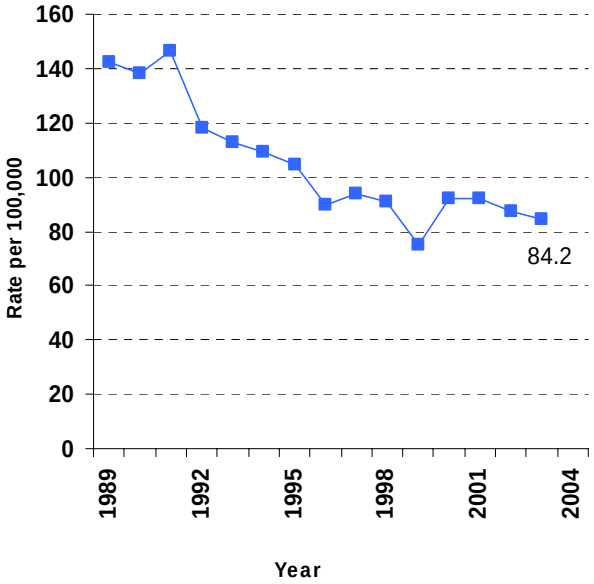
Time Trend [6,g]

Intentional Injury Hospitalization Rate, Ages 0-19 Per 100,000, WA, 1989-2003

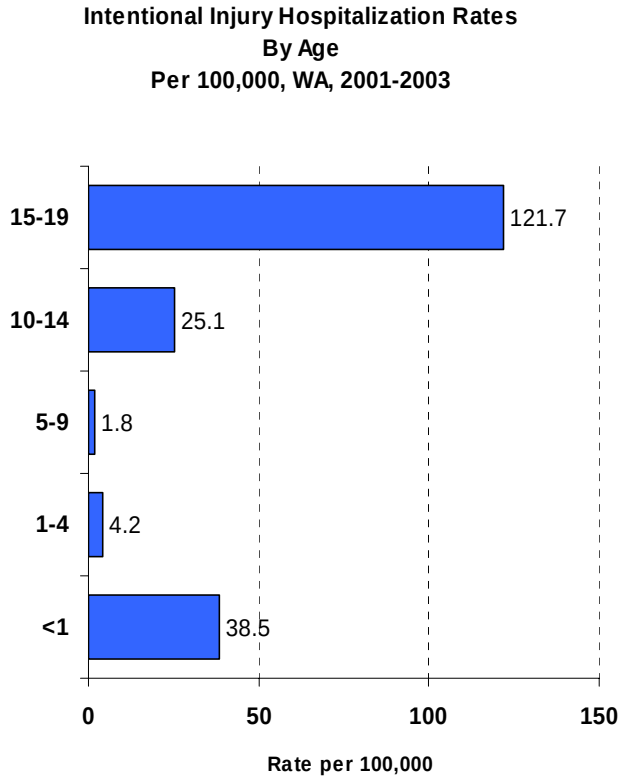


Suicide Attempt Hospitalizations: 15 to 19 Year Olds [6,g]

Nonfatal Suicide Attempt Hospitalizations Ages 15 -19 Per 100,000, WA, 1989-2003



Age [6,g]



Gender [6,g]

Leading Causes of Nonfatal Intentional Injury Hospitalizations 1999-2003, WA Children Ages 0-19 by Age [6,g]				
Causes				
Rank	**Ages <10**	**Ages 10-14**	**Ages 15-19**	**Ages 0-19**
1st	Firearms	Poisoning	Poisoning	Poisoning
2nd	Poisoning	Cut/Pierce	Struck by or against	Struck by or against
3rd	Cut/Pierce	Struck by or against	Cut/Pierce	Cut/Pierce

Data Sources

1. Washington State death certificate data: Vital Statistics 2003, Washington State Department of Health, Center for Health Statistics, March 2005.
2. Analysis Software: Public health – Seattle & King County, Epidemiology, Planning & Evaluation, Software for Public health Assessment (VistaPHw), 1991-.
3. Injury Prevention and Safety Program, Washington State Department of Health: http://www.doh.wa.gov/cfh/Injury/data_tables/table_directory.htm
4. Data from the Washington State Child Death Review Database, MCH Assessment Section, Washington State Department of Health, 2001-2003.
5. Healthy People 2010: Understanding and Improving Health, US Department of Health and Human Services, Washington DC. US Government Printing Office, 2000.
6. Washington State Department of Health, Center for Health Statistics, Comprehensive Hospital Abstract Reporting System (CHARS - August 2005 release). Data compiled by Washington State Injury and Violence Prevention Program. Available at: http://www.doh.wa.gov/cfh/Injury/data_tables/WA/nonfatal/NonfatalbyAge_2000-2004.pdf
7. Washington State Department of Health, Office of Community and Rural Health, November 2005.

Endnotes

a. For years after 1999 on, intentional self-harm (suicide) includes ICD-10 codes X60-X84 and Y87.0. Assault (homicide) includes ICD-10 codes X85-Y09 and Y87.1. For years 1980-1998, intentional self-harm includes ICD-9 codes E950-E959, and assaults include ICD-9 codes E960-E969. Comparability ratio (used to enable comparison of ICD-9 and ICD-10 coded data) for intentional injury mortality was 1.00 (SE 0.0005 for suicides and 0.0006 for homicides)
b. County specific rates for Intentional Injury Mortality are not provided because of the small number of deaths.
c. Population denominators for non-Hispanics are estimated by subtracting the number of Hispanics from the total population and may include unknowns.
d. AIAN – American Indian/Alaska Native
e. API – Asian or Pacific Islander
f. Significance was determined based on 95% Confidence Intervals.
g. Graphs reflect non-fatal injury hospitalizations

Low Birthweight for Singleton Births

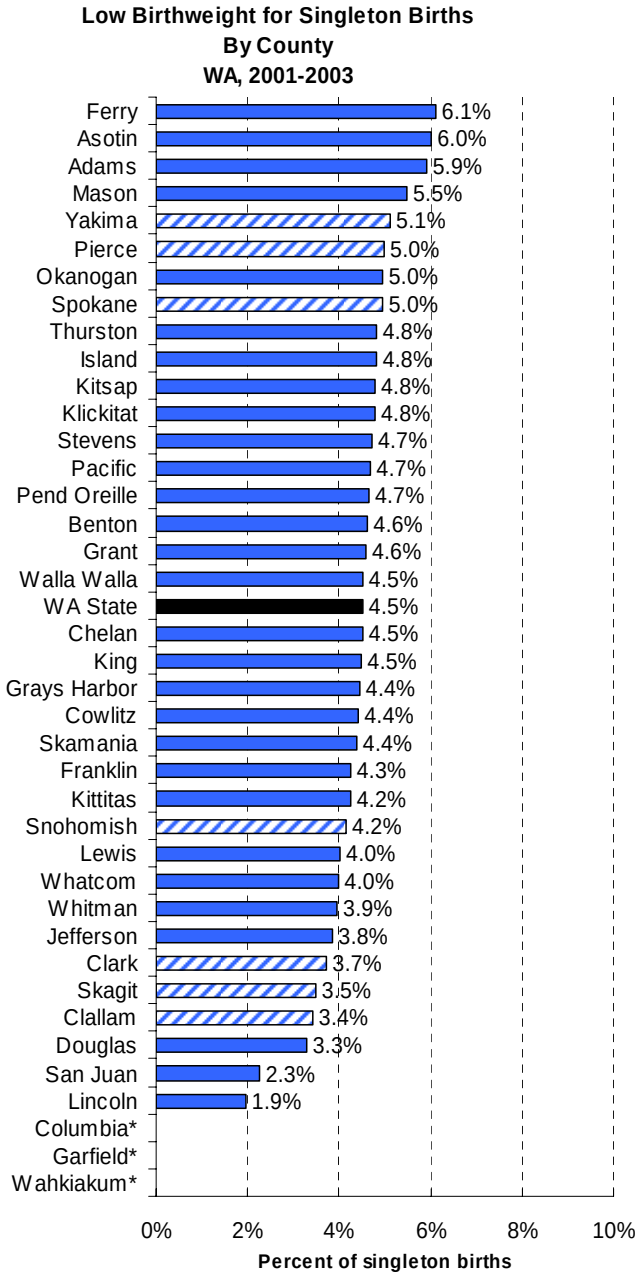
Publicly funded services to address Low Birthweight are described in First Steps, Nutrition Services, Tobacco Prevention and Treatment Services for Pregnant Women, and Substance Abuse Services for Women

Key Findings:

- Low birthweight (LBW) is a major contributor to infant mortality and morbidity, and care of the LBW infant is costly. These data are limited to singleton births in order to explore factors other than plurality (multiple births) which may influence LBW trends.
- In 2003, the LBW rate for singletons was 4.6%, representing 3,594 births in Washington State, compared to a national rate of 6.2%. The overall Washington LBW (which includes multiple births) was 6.1% or 4,857 births in 2003, compared to a national rate of 7.9%.[1,2,3]
- The overall Washington LBW rate increased significantly from 5.3% in 1990 to 6.1% in 2003. The singleton LBW rate also changed significantly from the 1990 rate of 4.3%, but the rate of increase was half that of all LBW.[1,2]
- Singleton LBW births were significantly higher among Black women compared to women of other races, and among women ages 15-19 and 40-44 compared to other age groups.[1]
- Singleton LBW births were highest among TANF women (6.2%) compared to other Medicaid programs (S-Women 4.7%, Non-Citizens 4.1%) and Non-Medicaid women (3.9%).[4]
- The National Healthy People 2010 objective is to reduce the overall LBW rate to no more than 5.0%. Washington has not yet met this objective.[5]

Definition: Low birthweight is a newborn birthweight less than 2,500 grams (5 lbs. 8 oz). The analysis in this chapter is limited to singleton (one baby) births.

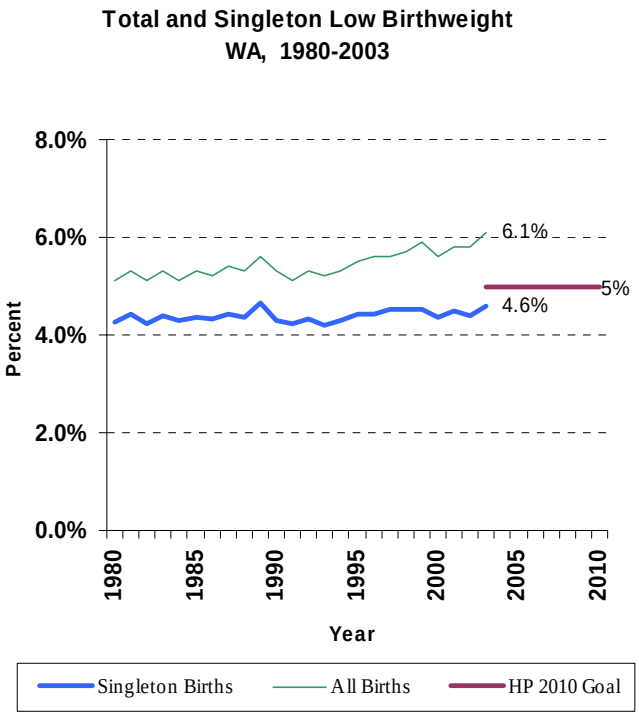
County [1,2,a]



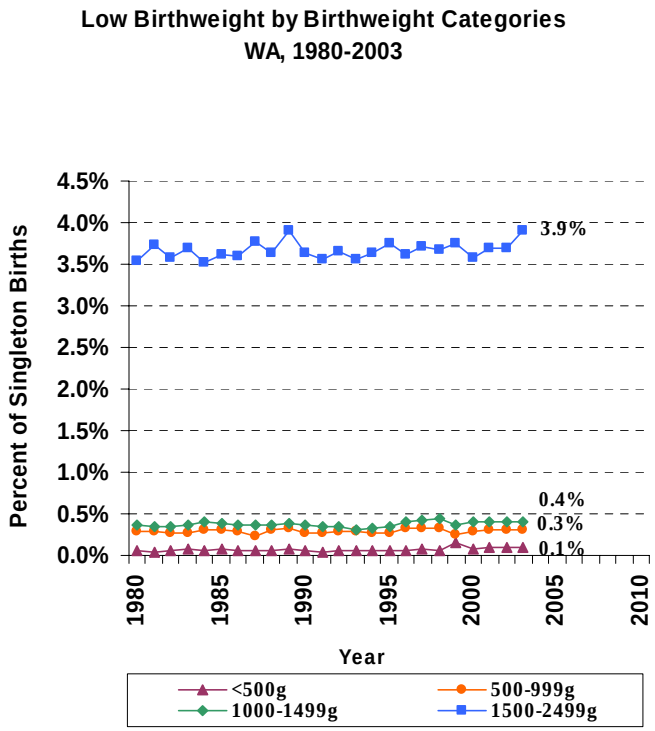
**County rate not calculated if less than 5 events*

Significantly different from state based on 95% confidence intervals

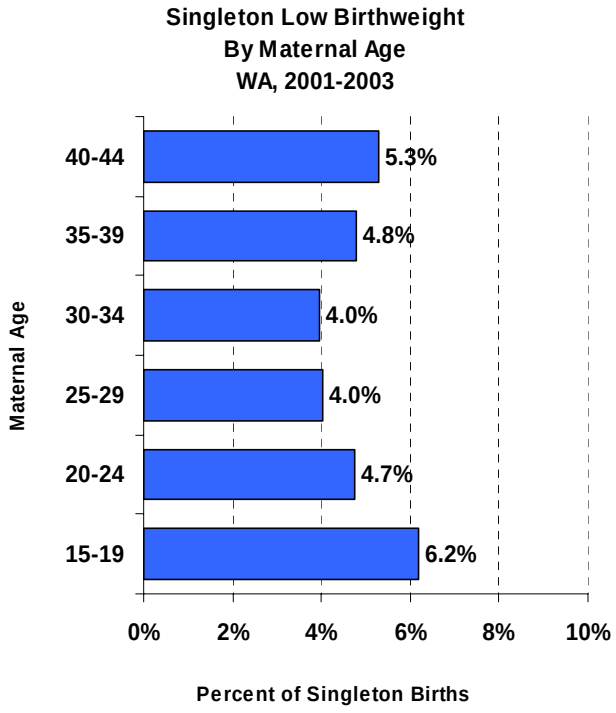
Time Trend [1,2,3]



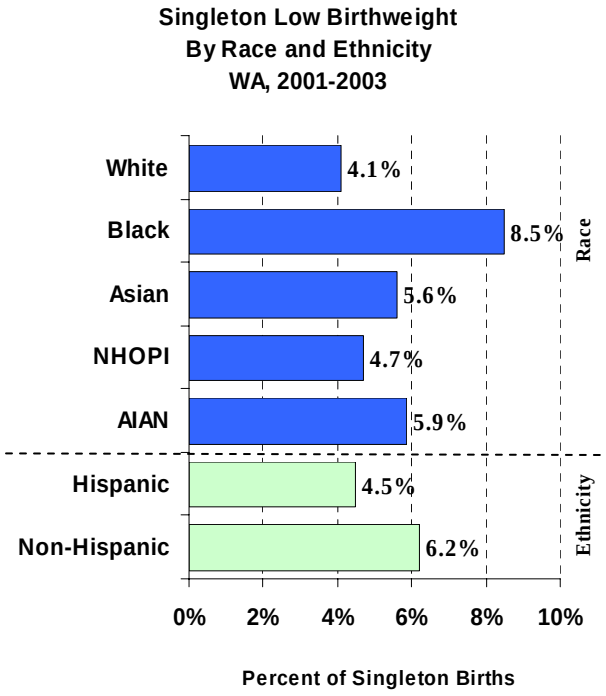
Birthweight Trend [1]



Age [1,2]

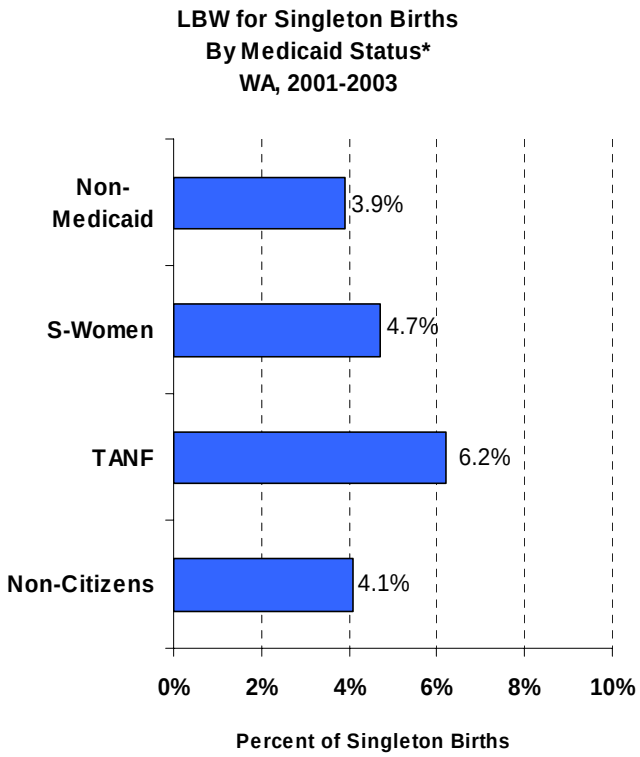


Race and Ethnicity [1,2,b,c]

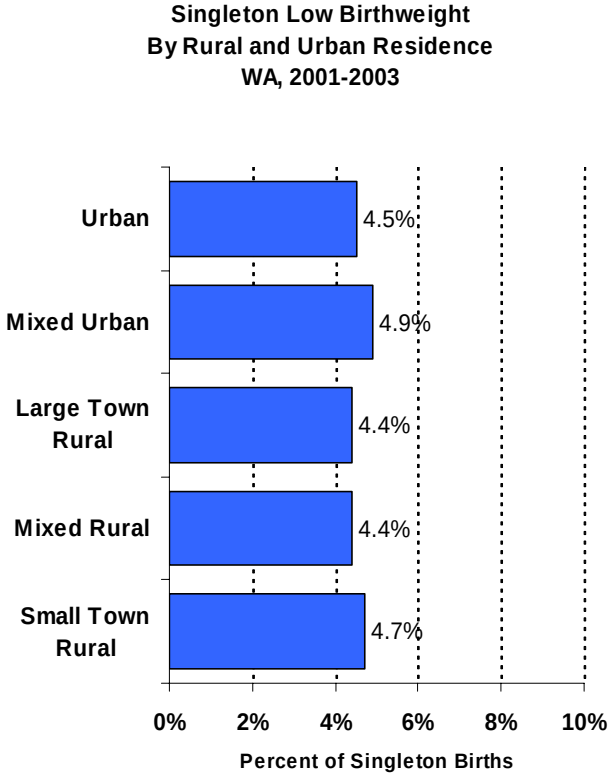


Infant Gender [1,2]

Medicaid Status [4]



Rural and Urban Residence [6,d]



***** Medicaid women received maternity care paid for by Medicaid. They are divided into three major subgroups (from highest to lowest socioeconomic status): **S-Women** - those women who are citizens and eligible to receive Medicaid because they are pregnant and have incomes at or below 185% FPL, **TANF** - those women who are very low income (generally < 50% FPL) and receive cash assistance (TANF) in addition to Medicaid, and **Non-Citizens** - those women who are not citizens and are eligible to receive Medicaid because they are pregnant and have incomes at or below 185% FPL. Non-citizens are not eligible for TANF although their incomes are often lower than women on TANF. All three Medicaid groups have incomes below most Non-Medicaid women.

Data Sources

1. Washington State birth certificate data: Vital Statistics 2003, Washington State Department of Health, Center for Health Statistics, March 2005.
2. Analysis Software: Public Health – Seattle & King County, Epidemiology, Planning & Evaluation, Software for Public Health Assessment (Vista PHw), 1991-.
3. Martin JA, Hamilton RE, Sutton PD, et al. Births: Final Data for 2003 : National Vital Statistics reports ; Vol 54 No. 2, Hyattsville, MD: National Center for Health Statistics, 2005. http://www.cdc.gov/nchs/data/nvsr/nvsr54/nvsr54_02.pdf
4. Cawthon, L. Characteristics of Women Who Gave Birth in Washington State. Washington State Department of Social and Health Services, First Steps Database, 2/23/05.
5. Department of Health and Human Services (US). Healthy People 2010: Understanding and Improving health. 2nd edition. Washington, DC: US Government Printing Office; November 2000.
6. Washington State Department of Health, Office of Community and Rural Health. November 2005 http://www.doh.wa.gov/hsqa/ocrh/

Endnotes

a. Significance was determined based on 95% Confidence Intervals
b. AIAN – American Indian/Alaska Native
c. NHOPI – Native Hawaiian Other Pacific Islander
d. Rural urban differences are based on county level RUCA codes calculated using 2000 census data (see Technical Notes for description of RUCA codes)

Mental Health Disorders: Child and Adolescent

Publicly funded services to address Mental Health are described in Mental Health Services and School-Based Health Centers. In addition, the DOH Injury program addresses suicide prevention.

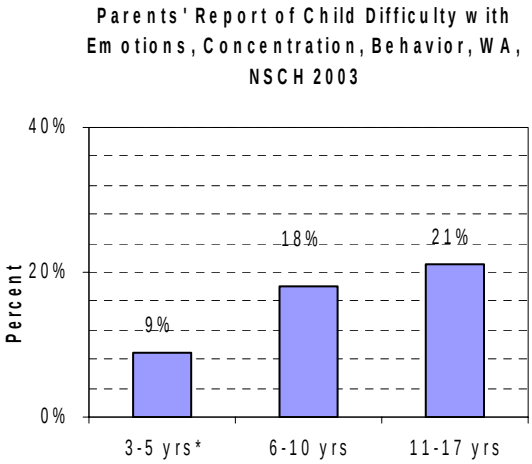
Definition: *Mental Illness* is a term that refers collectively to all mental disorders. Mental Disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning (U.S. Surgeon General, 1999). [1]

Key Findings:

- Few population-based data sources are available with information on mental illness among children and adolescents. Data which are available use differing definitions of mental illness (e.g., diagnosis or experience of symptoms). In addition, misdiagnosis of children, a concern among health care providers, may influence the data.[1]
- In 1999, the US Surgeon General reported that 20% of children 0-18 years experienced symptoms of mental disorders, with 5-9% of all children experiencing symptoms which impacted their ability to function.[2]
- Among Washington households with children surveyed in 2003, approximately 9% of parents of children 3-5 years* and 18% of parents of children 5-10 reported their child had difficulty with emotions, concentration, behavior or getting along with people.[3]
- Among these households, approximately 6% of parents reported their child had been diagnosed with ADHD/ADD. Similarly, about 6% of parents reported their child diagnosed with depression, and about 6% with a behavioral/conduct disorder. Prevalence increased with the age of child for ADHD/ADD and depression.[3]
- While hospitalizations only account for a small proportion of children and adolescents with mental health disorders, mental illness was the second leading cause of hospitalization among children in Washington State in 2001-2002. The statewide mental illness hospitalization rate for children 10-17 for 2001-2003 was 28.6 per 10,000.[4]
- Depression is one of the more prevalent mental disorders reported by youth. In 2002-2004, approximately 30% of Washington youth in the 8th, 10th and 12th grade reported experiencing symptoms of depression in the past 12 months. Females were more likely to report experiencing depressive symptoms than boys. Symptoms varied by race/ethnic group, but most differences were not statistically significant.[5]
- For all mental illnesses combined, several groups at high risk for mental illness in Washington have been identified.[c] These groups include youth in the juvenile justice system, children in foster care, and children with a parent with mental illness.[1]
- In 2003, approximately 60% of Washington youth in the state juvenile justice system had a mental health diagnosis, were taking psychotropic medication, or were suicidal at least one time in a 6-month period.[6]
- The 2005 Northwest Foster Care Alumni Study reported that 54% of foster care alumni reported one or more mental health disorders in the 12 months prior to interview.[7]
- The 2002 National Survey of American Families reported that children and adolescents whose parents experience symptoms of poor mental health or high parental aggravation were about three to five times as likely to have emotional and behavioral problems as children whose parents reported better mental health or only moderate aggravation.[8]
- Additional groups may also be at increased risk for mental illness based on the scientific literature, including American Indian/Alaska Natives, gays and lesbians, refugees and immigrants, and homeless youth. However, Washington-specific data are not available.[1]

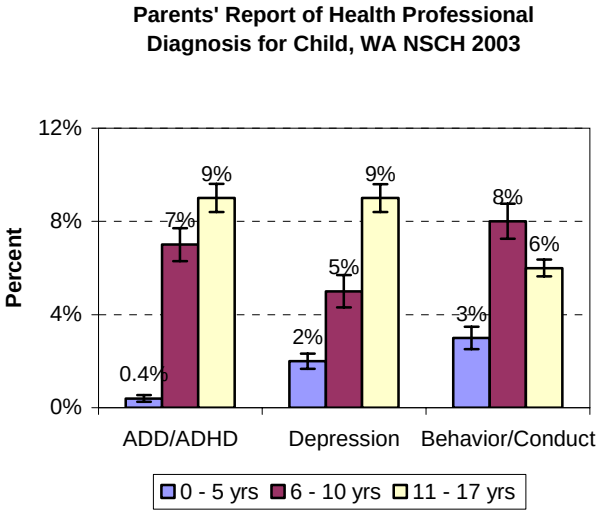
** Data only available for children ages 3 to 5*

Prevalence Symptoms Mental Disorders

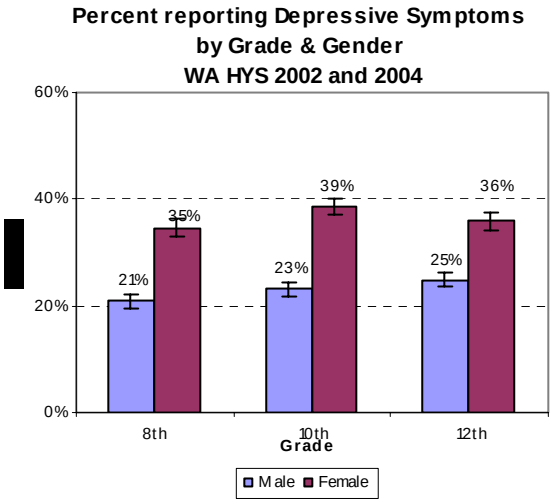


** Data only available for children ages 3 to 5*

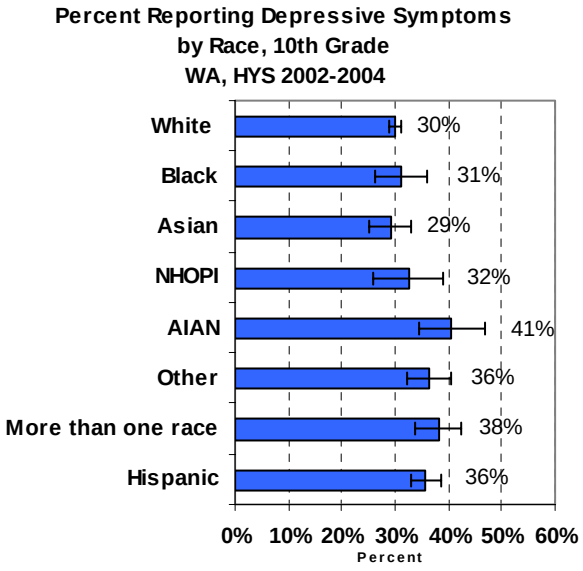
Prevalence by Diagnosis and Age



Depressive Symptoms by Gender and Grade

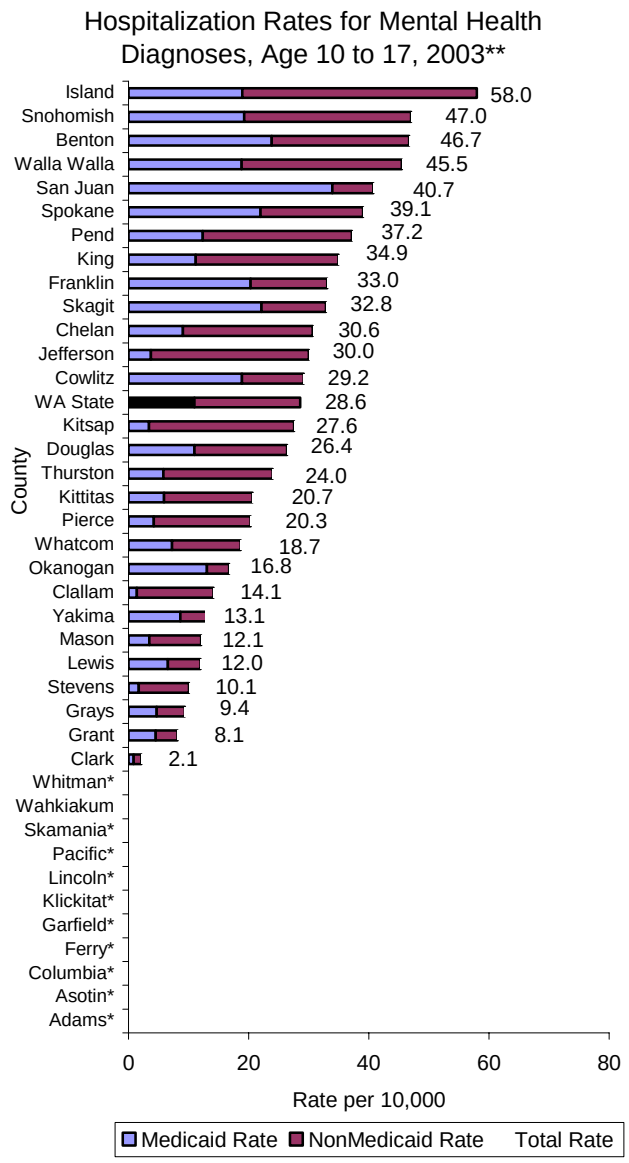


Depressive Symptoms by Race/Ethnicity



**In the Healthy Youth survey, Hispanic ethnicity is asked in the same question as race. Students are asked to choose one or more races, including Hispanic ethnicity, as appropriate.*

County Hospitalization Rate [4]



**County rate not calculated if less than 5 events*
*** Does not include hospitalizations through the Children's Long-Term Inpatient Program*

Data Sources

1. Kander, M. Children's Mental Health in Washington State: A Public Health Perspective Needs Assessment. Washington State Department of Health, Office of Maternal and Child Health, 2006
2. U.S. Department of Health and Human Services. Mental Health: A Report of the Surgeon General—Executive Summary. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.
3. 2003 National Child Health Survey, Department of Health and Human Services, CDC, National Center for Health Statistics, Hyattsville, Maryland, April, 2005
4. Comprehensive Hospital Abstract Reporting System (CHARS), Washington State Department of Health, 1990-2003.
5. Washington State Healthy Youth Survey 2002 & 2004. Washington State Office of Superintendent of Public Instruction, Department of Health, Department of Social and Health Services, and Department of Community, Trade, and Economic Development and RMC Research Corporation. Website: http://www3.doh.wa.gov/HYS/ASPX/HYSQuery.aspx
6. Governor's Juvenile Justice Advisory Committee (March, 2003) 2003 Juvenile Justice Report Summary retrieved October 21, 2003 from: http://www.juvenilejustice.dshs.wa.gov/annualrpt.html
7. Pecora PJ, Kessler RC, Williams J et al. Improving family foster care: Findings from the Northwest Foster Care Alumni Study. Seattle, WA: Casey Family Programs, 2005. Available at http://www.casey.org
8. Brandon, R., Hill, S., Mandell, D.J., Carter, L. (2003). Family Matters: Mental Health of Children and Parents Washington Kids Count, Human Services Policy Center, Evans School of Public Affairs, University of Washington.

Endnotes

a. Mental health hospitalization rates were calculated using ICD-9 codes 291,292, 294-309, and 311 and do not include hospitalizations at military and state hospitals.

b. Depressive symptoms were measured by positive responses to the question, "During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities?"

c. Populations at high risk for mental illness were defined as those groups with a reported prevalence of mental illness greater than 20%. Characteristics, variables or hazards that, if present for a given individual, make it more likely that this individual, rather than someone selected at random from the general population, will develop a disorder (U.S. Surgeon General, 1999).

Oral Health

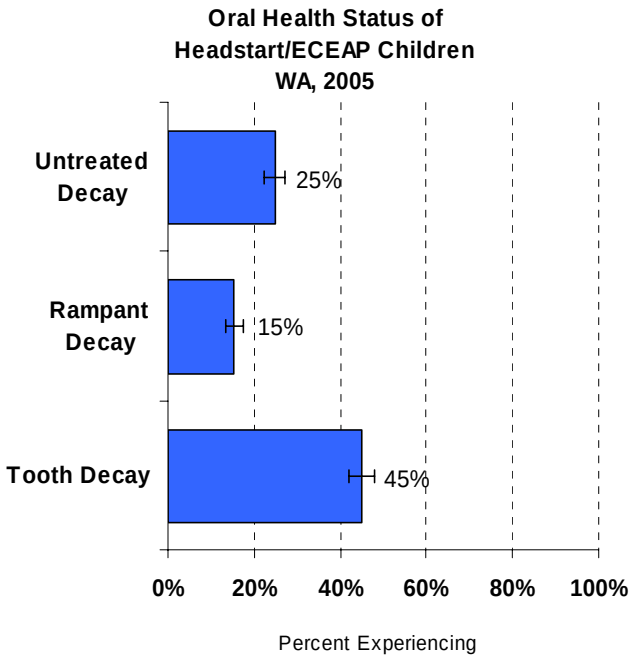
Publicly funded services to address Oral Health are described in Oral Health Services.

Definition: Oral health deals with the prevention and treatment of common oral and craniofacial diseases and conditions such as tooth decay and periodontal (gum) disease. In this chapter, tooth decay is used as a measure of poor oral health. Rampant decay is defined as 7 or more teeth decayed, missing, or filled.

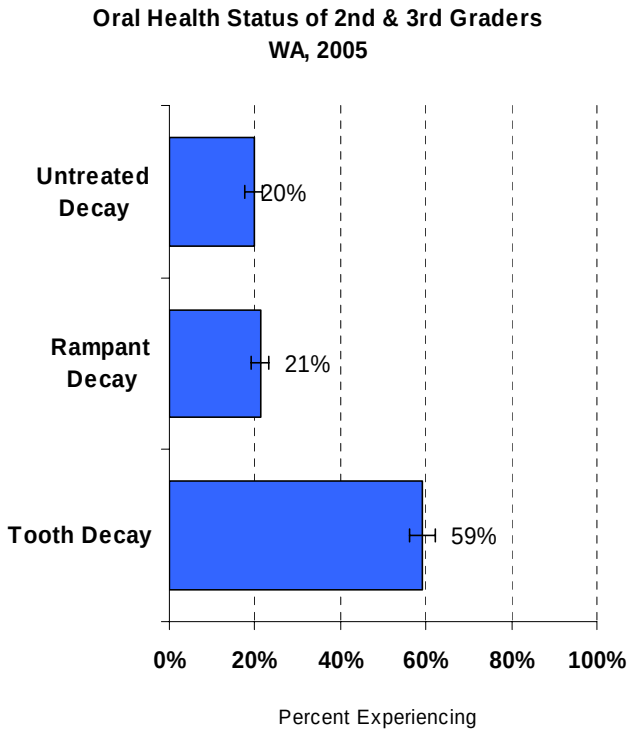
Key Findings:

- Oral health is an essential component of health and quality of life. Tooth decay is the single most common chronic disease of childhood (5 times more common than asthma), and affects about 78% of all children by age 17.[1]
- Poor oral health affects children's ability to concentrate and learn, as well as their speech development, eating habits, activity levels and self-esteem.[1]
- Tooth decay is a problem for Washington's children. In 2005, about 59% of 2nd-3rd graders experienced decay compared to the HP2010 objective of 42% for children 6-8 yrs. About 21% experienced rampant decay.[2,3]
- Many children are not getting the dental care they need. The 2005 Washington State Smile Survey showed that about 20% of 2nd-3rd graders experienced untreated decay, and only 45% had received dental sealants. HP2010 objectives are 21% and 50%, respectively.[2,3]
- Low income children also experience high rates of decay. No Washington data of all preschool children are available, however, 45% of Headstart/ECEAP children experienced decay compared to the HP2010 objective of 11% for all 2-4 year olds.[2,3]
- Oral health disparities persist in our state, with minority, low-income, and non-English speaking children having the highest levels of dental disease, highest levels of untreated decay, and the lowest levels of dental sealants.
- Community water fluoridation is the most cost-effective, equitable, and safe mans to provide protection from tooth decay. The Centers for Disease Control and Prevention indicate that 59% of the Washington population has access to optimally fluoridated water through public water systems compared to the HP2010 objective of 75%.[3,4]
- Research suggests a potential relationship between poor oral health during pregnancy and preterm/low birthweight deliveries. Treating periodontal disease during pregnancy may lead to improved birth outcomes. Cariogenic bacteria may also be transmitted by the mother to the child.[5]
- PRAMS data for 2001-2003 show that about 28% of mothers overall reported needing to see a dentist for a problem during their pregnancy, with women on Medicaid much more likely to report a dental problem than Non-Medicaid women.[6,7]
- Approximately 69% of mothers who reported a dental problem also reported they went to the dentist during their pregnancy. This varied by Medicaid status. Only about 58% of TANF women and S-women who reported a dental problem said they went to the dentist compared to about 84% of Non-Citizens and 76% of Non-Medicaid women who reported a dental problem.[6,7]

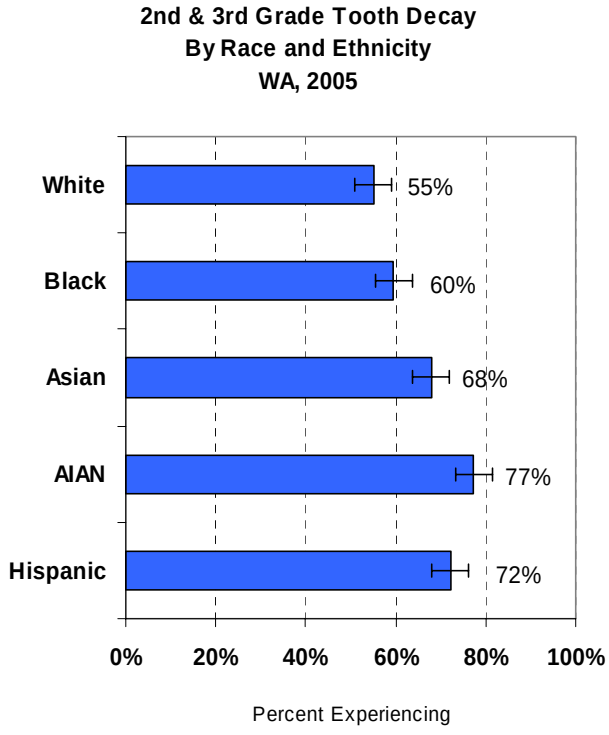
Head Start/ECEAP Children



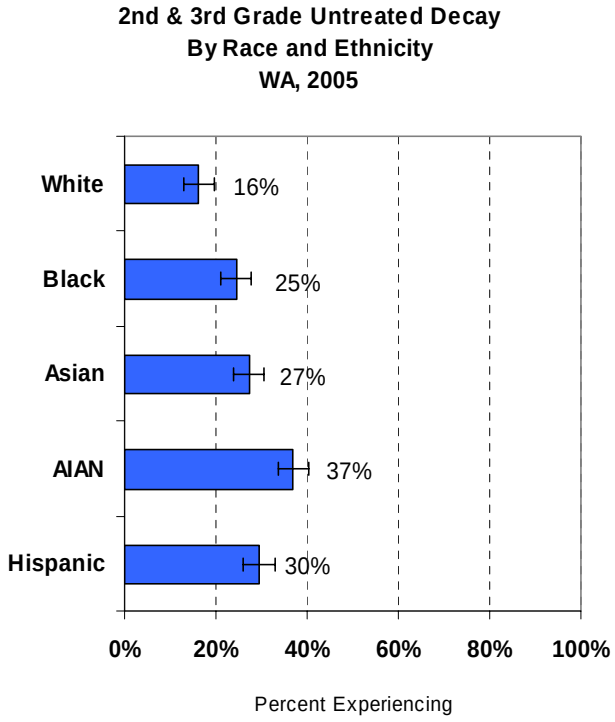
2nd and 3rd Graders



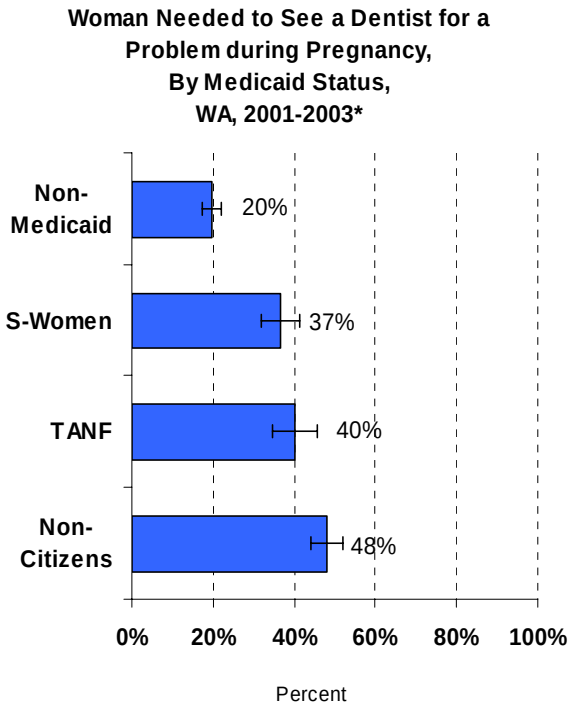
Tooth Decay



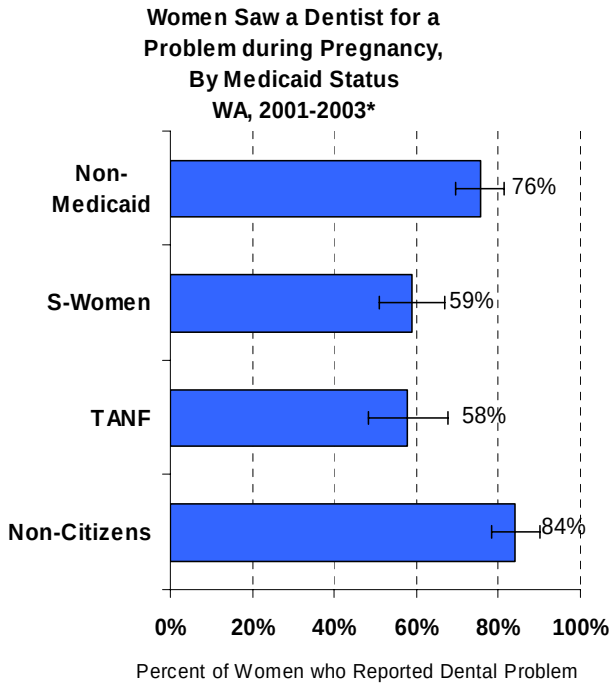
Untreated Decay



Needed Dental Care



Received Dental Care



***** Medicaid women received maternity care paid for by Medicaid. They are divided into three major subgroups (from highest to lowest socioeconomic status): **S-Women** - those women who are citizens and eligible to receive Medicaid because they are pregnant and have incomes at or below 185% FPL, **TANF** - those women who are very low income (generally < 50% FPL) and receive cash assistance (TANF) in addition to Medicaid, and **Non-Citizens** - those women who are not citizens and are eligible to receive Medicaid because they are pregnant and have incomes at or below 185% FPL. Non-citizens are not eligible for TANF although their incomes are often lower than women on TANF. All three Medicaid groups have incomes below most Non-Medicaid women.

Data Sources

1. U.S. Department of Health and Human Services, Oral Health in America: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.
2. Smile Survey 2005, Washington State Department of Health, Maternal and Child Health Office, July 2005.
3. Department of Health and Human Services (US). Healthy People 2010: Understanding and Improving Health. Oral Health Objectives. Washington, DC. http://www.healthypeople.gov/document/html/volume2/21oral.htm
4. Center for Disease Control and Prevention, Oral Health Resources. 2004 Data. Website: http://www2.cdc.gov/nccdphp/doh/synopses/StateDataV.asp?StateID=WA&Year=2004
5. Public health implications of periodontal infections in adults: conference proceedings. Journal of Public Health Dentistry, 65(1), Winter 2005.
6. Washington Pregnancy Risk Assessment Monitoring System (PRAMS), 2001-2003. Washington State Department of Health.
7. First Steps Database, Research and Data Analysis Division, Washington State Department of Social and Health Services.

Endnotes

a. AIAN – American Indian/Alaska Native
b. API – Asian or Pacific Islander
c. Significance based on 95% confidence intervals

Perinatal Behaviors

Publicly funded services to address Perinatal Behaviors are described in First Steps, Family Planning, and Nutrition Services

Definition: Self-reported data from the 2001-2003 Pregnancy Risk Assessment Monitoring System (PRAMS) on maternal behaviors and experiences before, during, and after pregnancy among Washington State residents who delivered live born infants. Perinatal behaviors include pre-pregnancy multivitamin use, breastfeeding, sleep position of infant, and postpartum birth control.

Key Findings:

Multivitamin Use

- In 2000, PRAMS began asking mothers about multivitamin use. From 2001-2003, an estimated 54% of mothers responded they did not take multivitamins (MVI) in the month before their pregnancy. Mothers who were least likely to take multivitamins were younger or Medicaid recipients, regardless of Medicaid program.[1,2,a]
- American Indian/Alaska Natives, Blacks, and Hispanics were more likely than other races/ethnicities to report no multivitamin use prior to pregnancy.[1,a]
- The Healthy People 2010 objective is for 80% of pregnancies to begin with an optimal folic acid level.[3]

Breastfeeding

- From 2001-2003, about 69% of mothers breastfed their infant for 8 or more weeks while another 9% of mothers breastfed 4-7 weeks.
- Mothers under age 20 were significantly less likely to breastfeed for 8+ weeks (about 42%), and mothers age 30 and older were significantly more likely to breastfeed 8+ weeks (about 78%) than women 20-29 years.[1,a]
- Black and American Indian/Alaska Native mothers were significantly less likely to breastfeed 8 or more weeks than mothers of other races/ethnicities.[1,a]
- TANF women were least likely to breastfeed 8+ weeks (45%) compared to women in other Medicaid programs and women not receiving Medicaid coverage.[1,2]
- Washington is currently meeting the Healthy People 2010 objective for 75% of mothers to breastfeed in the early postpartum period.[3]

Sleep Position

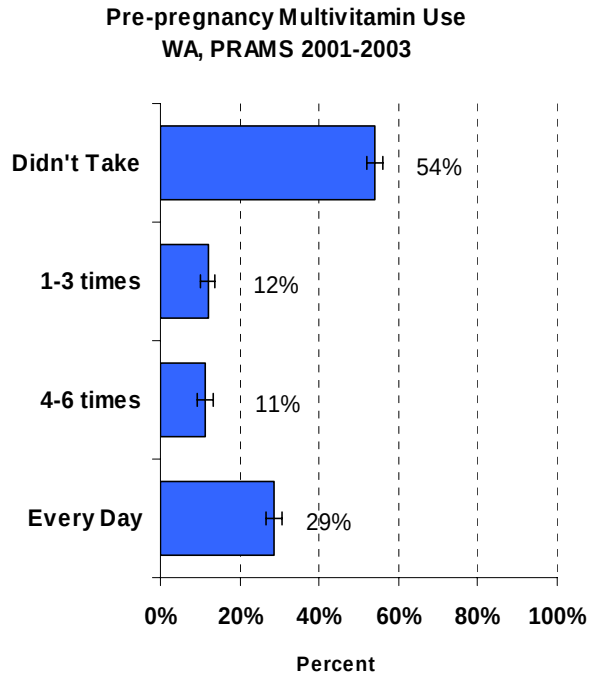
- During 2001-2003, an estimated 74% of mothers said that they placed infants on their backs when they put them to sleep.[1]
- Black mothers were less likely than other mothers to place their babies to sleep on their backs. Mothers not receiving Medicaid were significantly more likely to place their babies on their back when they put them to sleep (about 77%) compared to Medicaid recipients, regardless of Medicaid program.[1,2,a]
- There was no significant difference in placing babies on their back between maternal age groups.
- Washington is currently meeting the Healthy People 2010 objective for 70% of healthy full-term babies to be put down to sleep on their backs.[2]

Postpartum Birth Control

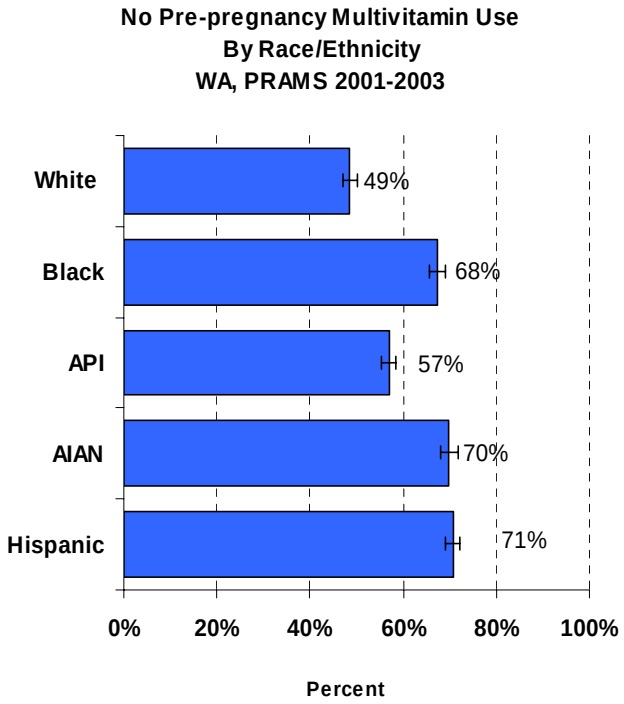
- About 85% of mothers were using birth control when surveyed 2-5 months postpartum.[1]
- There were no significant differences in postpartum birth control use between by maternal age or Medicaid status.[1,2,a]
- Among the main reasons women gave for not using postpartum birth control were they weren't having sex (34%), they didn't want to (23%), and other reasons (29%).[1]

Multivitamin Use

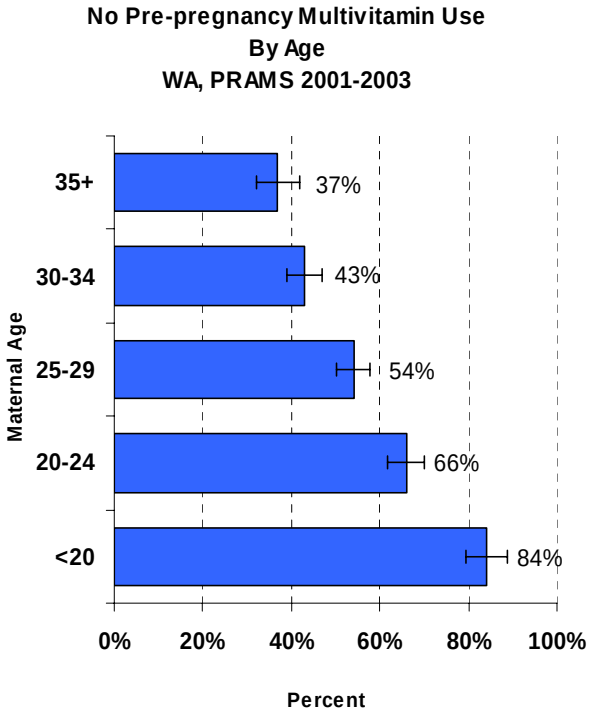
Overall [1]



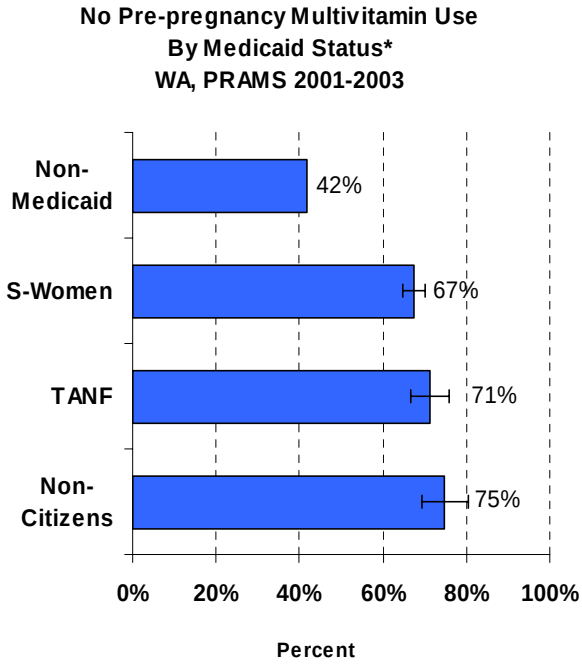
Race and Ethnicity [1,b,c]



Maternal Age [1]

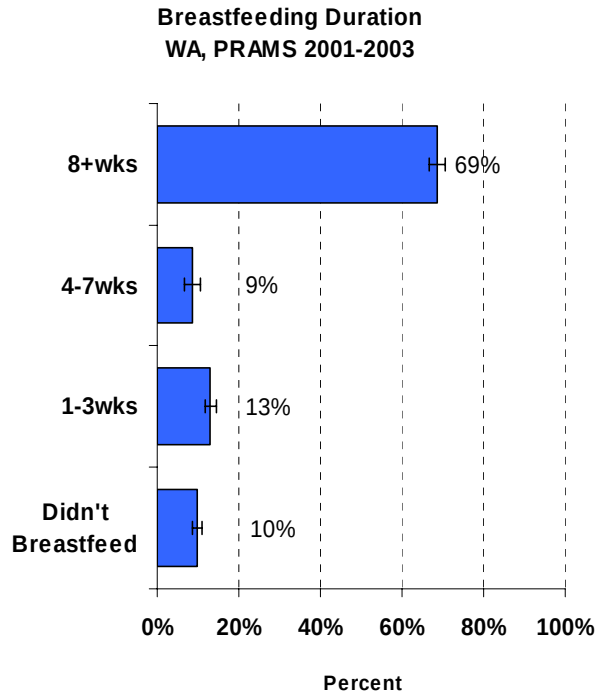


Medicaid Status [1,2,d]

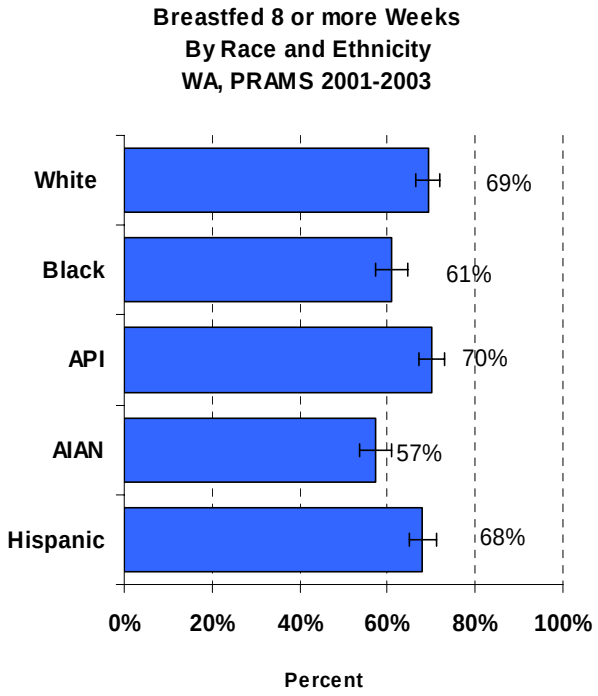


Breastfeeding Duration

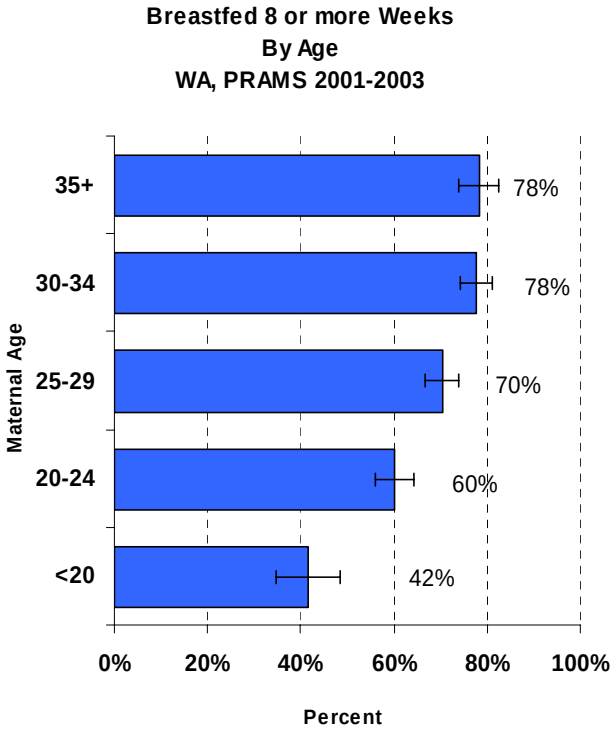
Overall [1]



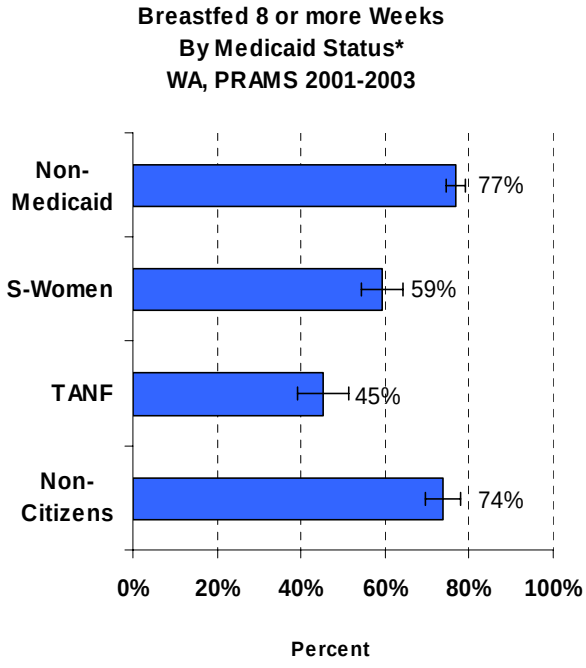
Race/Ethnicity [1,b,c]



Maternal Age [1]

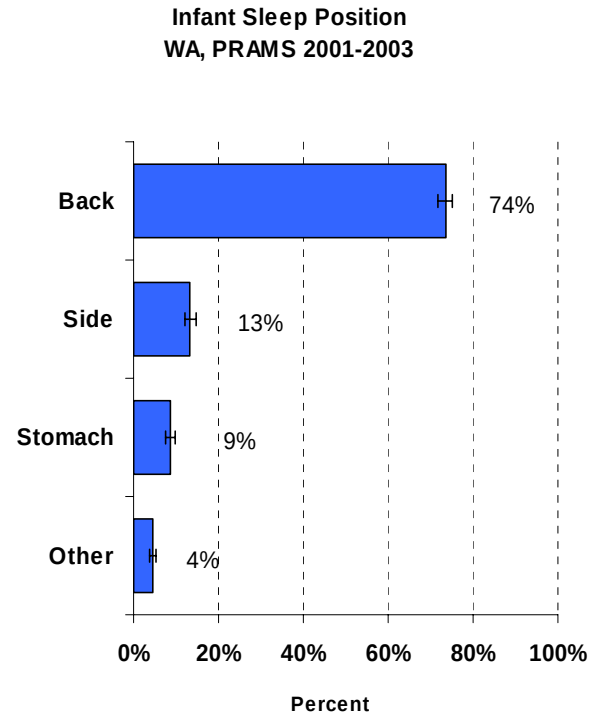


Medicaid Status [1,2,d]

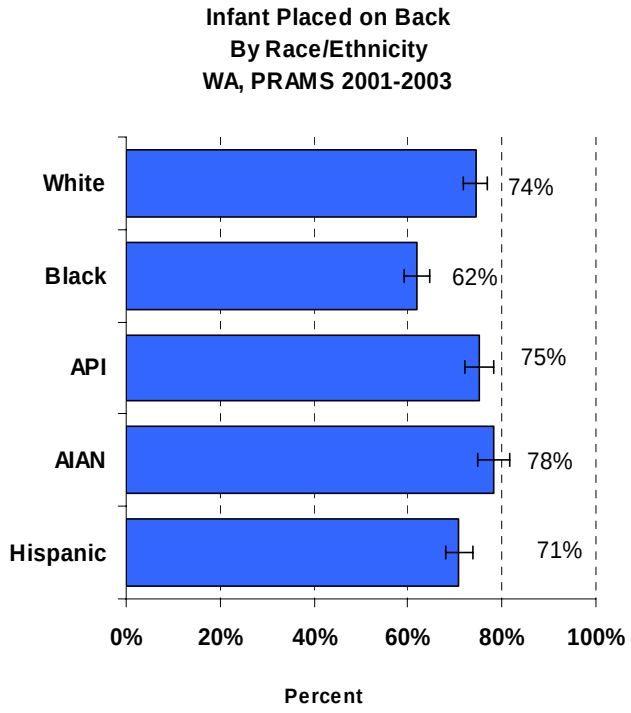


Infant Sleep Position

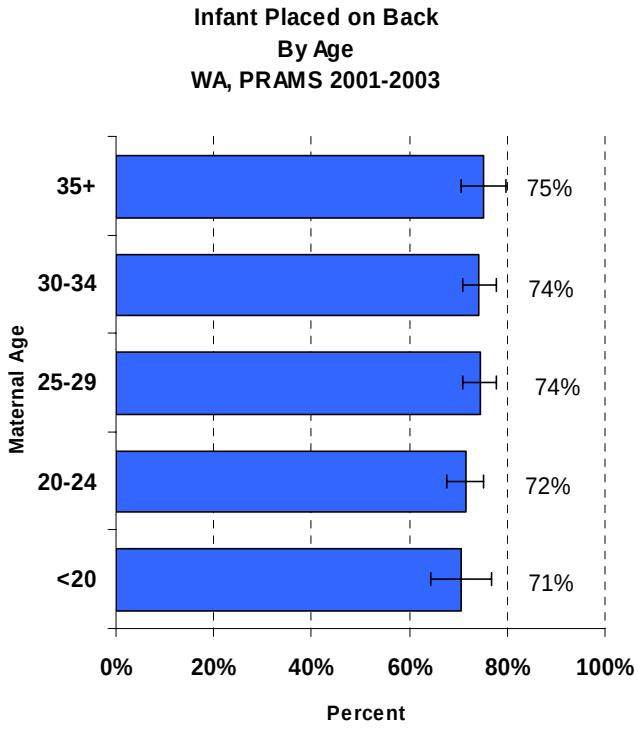
Overall [1]



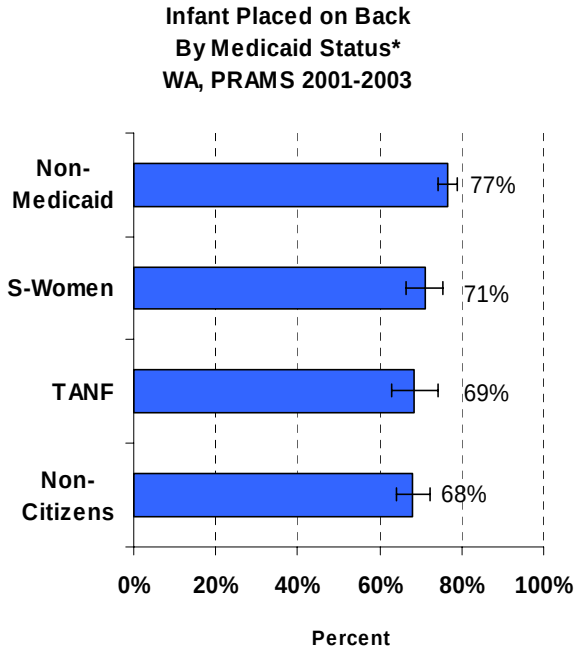
Race and Ethnicity [1,b,c]



Maternal Age [1]

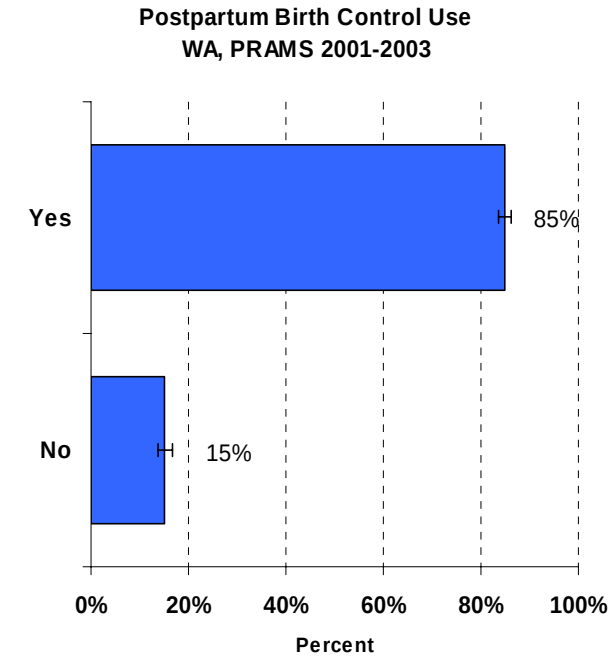


Medicaid Status [1,2,a,d]

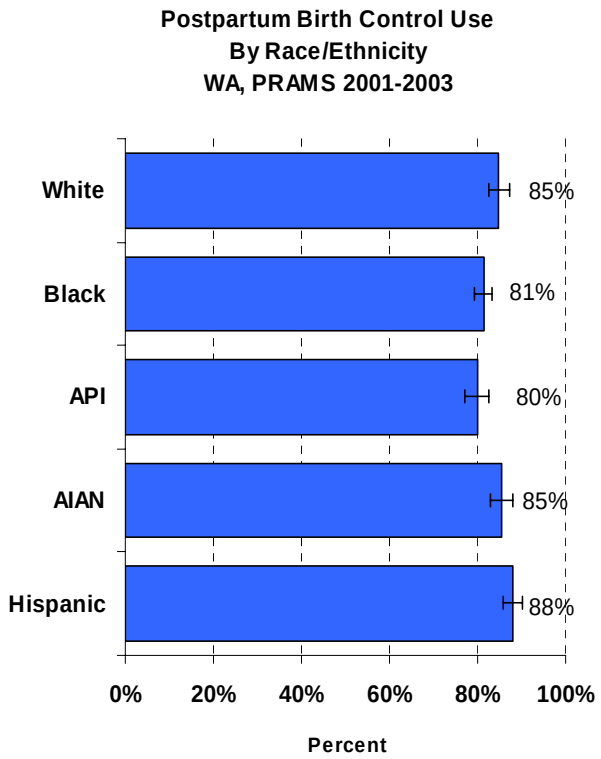


Postpartum Birth Control

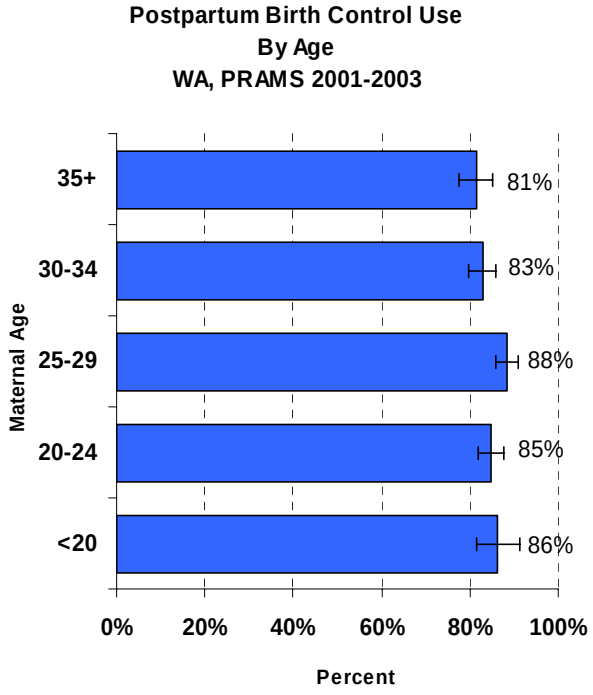
Overall [1]



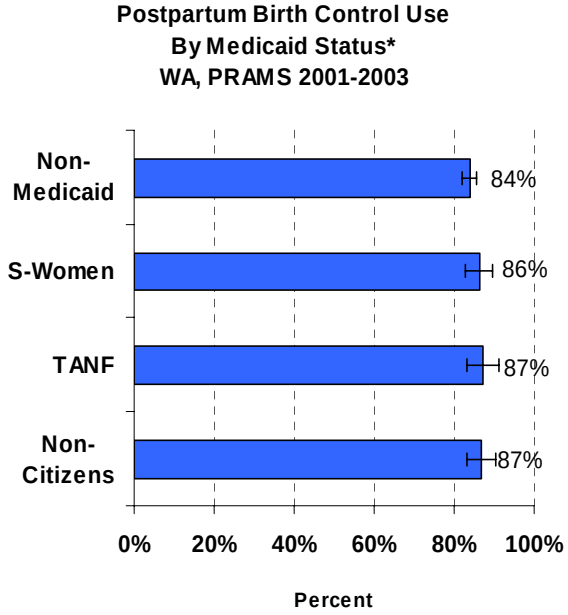
Race and Ethnicity [1,b,c]



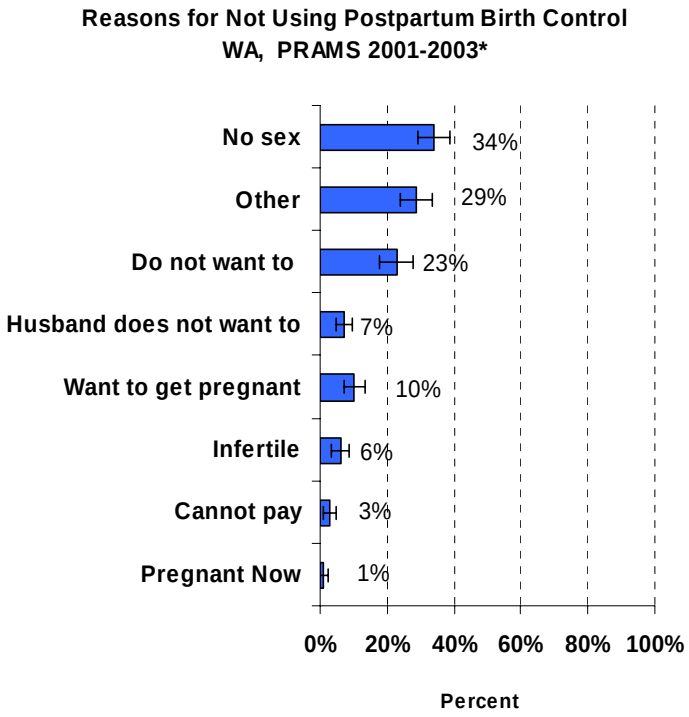
Maternal Age [1]



Medicaid Status [1,2,d]



Reasons for No Birth Control Postpartum [1,a]



*Respondents could select all responses that applied, so proportions will not add to 100%.

Data Sources

1. Washington Pregnancy Risk Assessment Monitoring System (PRAMS), 2001-2003.
2. First Steps Database. Research and Data Analysis Division, Washington State Department of Social and Health Services.
3. Department of Health and Human Services (US). Healthy People 2010: Understanding and Improving health. 2nd edition. Washington, DC: US Government Printing Office; November 2000.

Endnotes

a. Significance was determined based on 95% Confidence Intervals
b. AIAN – American Indian and Alaska Native
c. API – Asian or Pacific Islander
d. Medicaid women received maternity care paid for by Medicaid. They are divided into three major subgroups (from highest to lowest socioeconomic status): **S-Women** - those women who are citizens and eligible to receive Medicaid because they are pregnant and have incomes at or below 185% FPL, **TANF** - those women who are very low income (generally < 50% FPL) and receive cash assistance (TANF) in addition to Medicaid, and **Non-Citizens** - those women who are not citizens and are eligible to receive Medicaid because they are pregnant and have incomes at or below 185% FPL. Non-citizens are not eligible for TANF although their incomes are often lower than women on TANF. All three Medicaid groups have incomes below most Non-Medicaid women.

Prenatal Care

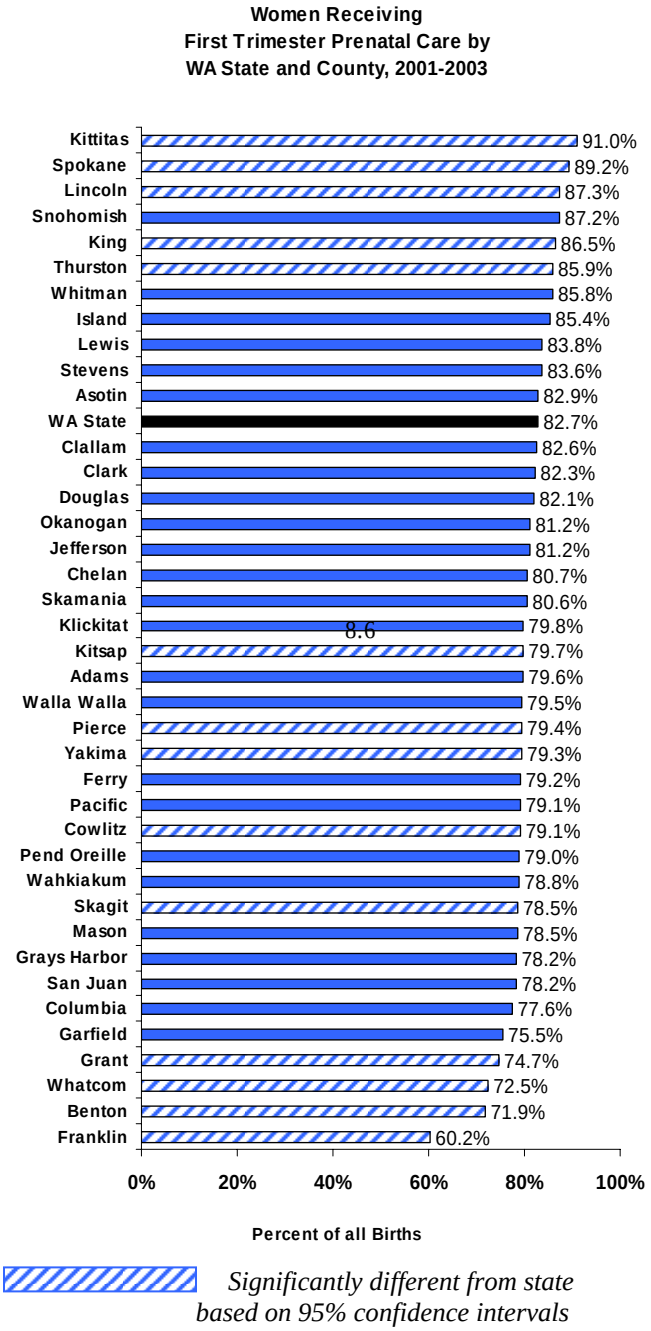
Publicly funded services to address Prenatal Care are described in First Steps and Healthy Mothers, Healthy Babies.

Key Findings:

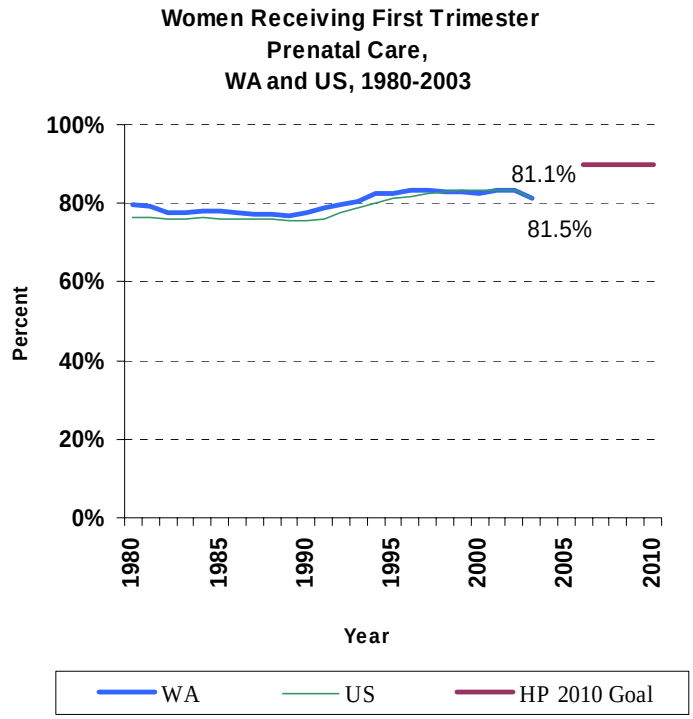
- Early and continuous prenatal care is considered the best strategy for improving the long-term health of the mother and preventing adverse birth outcomes.
- The large proportion of birth certificates with missing data on prenatal care initiation continues to be a reporting issue, even more so in 2003 with the transition to a new birth certificate. In 2003, month of onset of prenatal care was missing for 19.4% of live births, inhibiting our ability to accurately assess recent trends in access to prenatal care.[1]
- In 2003, an estimated 81.6% of Washington State pregnant women entered prenatal care during the first trimester (first three months) of pregnancy, compared to the national figure of 84.1%.[1,2]
- In 2001-2003, the women who were significantly more likely to begin prenatal care services in the first trimester were women over age 19, White women, Asian women, Non-Hispanic women, and Non-Medicaid women.[1,2,4]
- Washington is not yet meeting the Healthy People 2010 goal to increase the percentage of all pregnant women who receive prenatal care in the first trimester to 90%.[3]

Definition: Prenatal care is comprehensive medical care provided for the mother and fetus. Services include screening and treatment for medical conditions, and identification and interventions for behavioral risk factors associated with poor birth outcomes. First trimester is the first three months of pregnancy. These data include only women with a live birth.

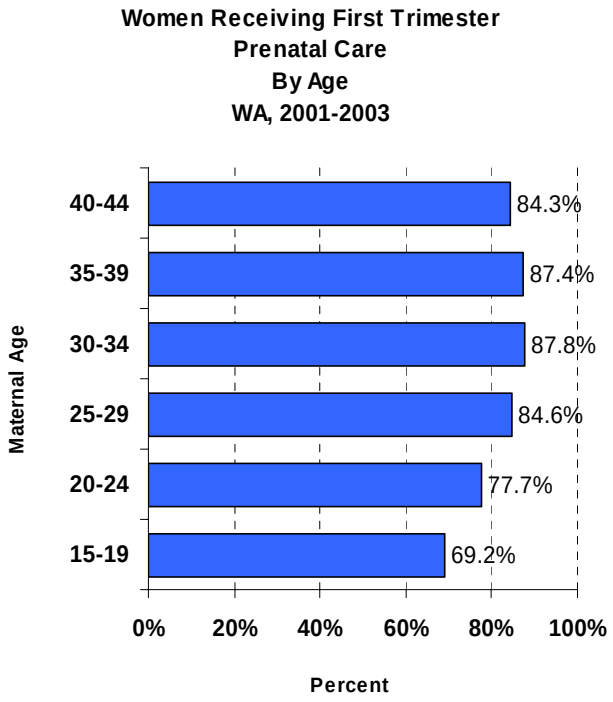
County [1,a]



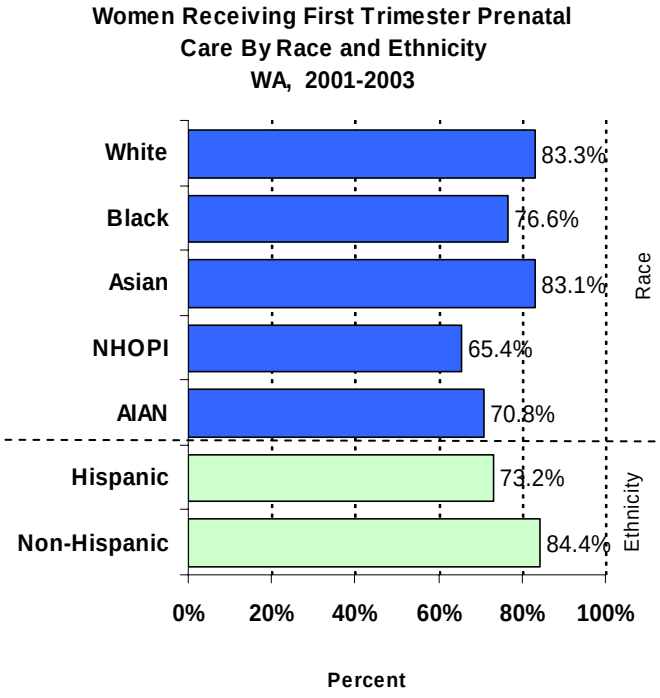
Time Trend [1,2]



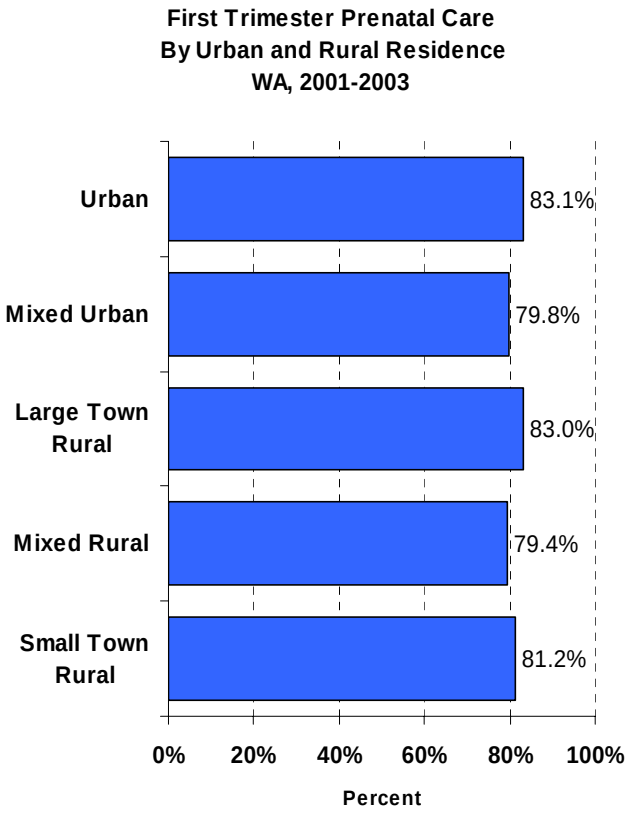
Maternal Age [1]



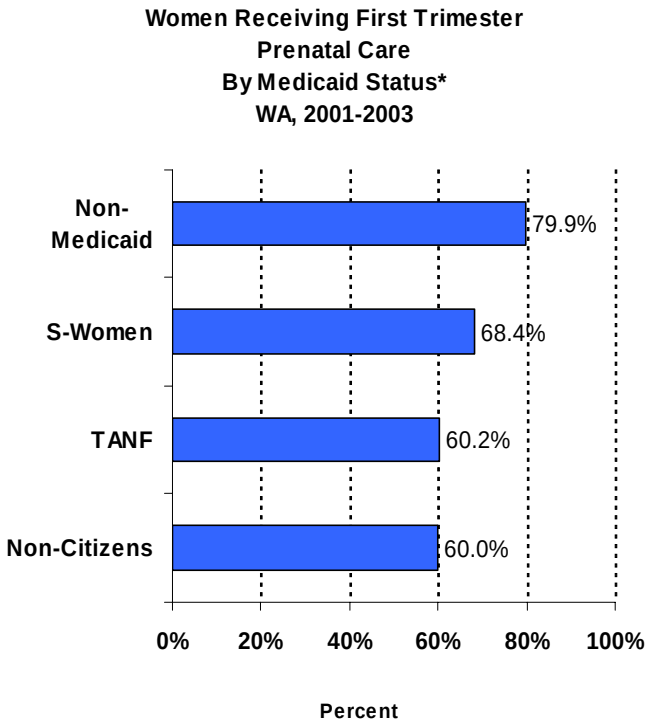
Race and Ethnicity [1,b,c]



Rural and Urban Residence [5,d]



Medicaid Status [4]



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Data Sources

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3. Department of Health and Human Services (US). Healthy People 2010: Understanding and Improving health. 2nd edition. Washington, DC: US Government Printing Office; November 2000.
4. Cawthon, L. Characteristics of Women Who Gave Birth in Washington State, Washington State Department of Social and Health Services, First Steps Database, 2/23/05
5. Washington State Department of Health, Office of Community and Rural Health, November 2005.

Endnotes

a. Significance was determined based on 95% Confidence Intervals
b. AIAN – American Indian/Alaska Native
c. NHOPI – Native Hawaiian Other Pacific Islander
d. Rural urban differences are based on county level RUCA codes calculated using 2000 census data (see Technical Notes for description of RUCA codes)

Preterm Delivery for Singleton Births

Publicly funded services to address Preterm Delivery are described in First Steps and Substance Abuse Services for Pregnant Women

Key Findings:

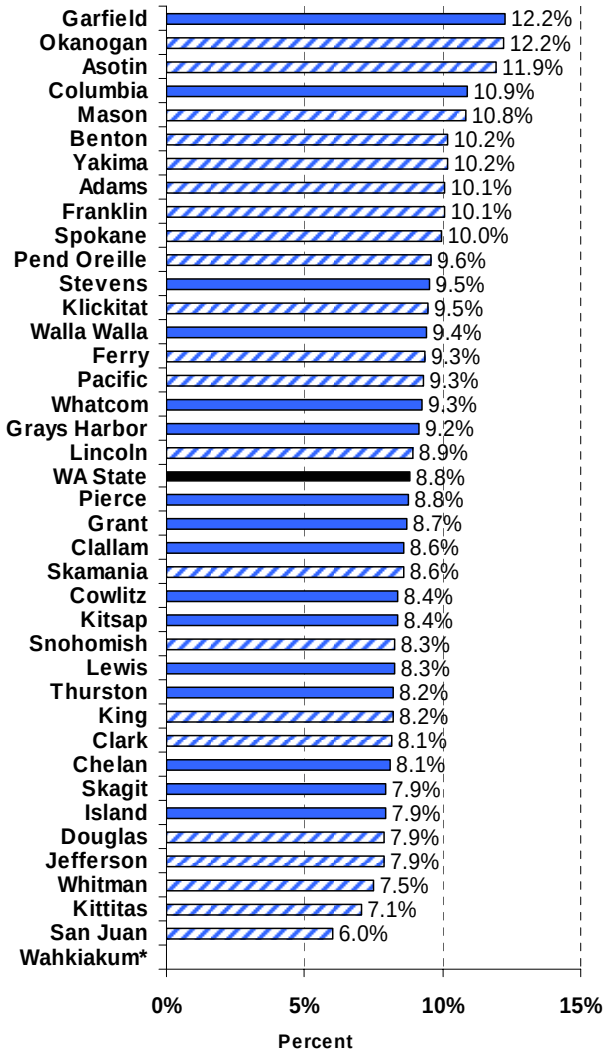
- Trends in preterm delivery have been greatly influenced by the rise in multiple births. Therefore, these data are limited to singleton (one baby) births, unless otherwise noted.
- Total preterm delivery (includes multiple births) in Washington increased from 8.4% in 1993 to 10.0% in 2003. During the same period, singleton preterm delivery increased from 7.6% to 8.8%. Nationally, total and singleton preterm delivery has also been increasing. In 2003, 12.3% of all births in the US were preterm, and 10.6% of singleton births in the US were preterm.[1,2]
- The rate of singleton preterm birth is almost twice the singleton low birthweight rate. Almost 70% of singleton preterm infants born in Washington from 2001-2003 were normal birthweight (≥ 2500 grams) (Data not shown.)
- White women and Non-Hispanic women in Washington State had significantly lower singleton preterm delivery rates compared to women of other races/ethnicities.[1,a]
- TANF recipients were significantly more likely to have a singleton preterm delivery than other Medicaid or non-Medicaid women.[3,a]
- From 2001-2003, women ages 25 to 34 were significantly less likely to have a preterm delivery than both older and younger women.[1,a]

Definition: Preterm delivery is defined as a live birth before 37 completed weeks of gestation. This report is limited to data on singleton (one baby) births, unless otherwise noted.

- Washington is not yet meeting the Healthy People 2010 objective to reduce overall preterm birth to no more than 7.6 per 100 births.[4]

County [1,a]

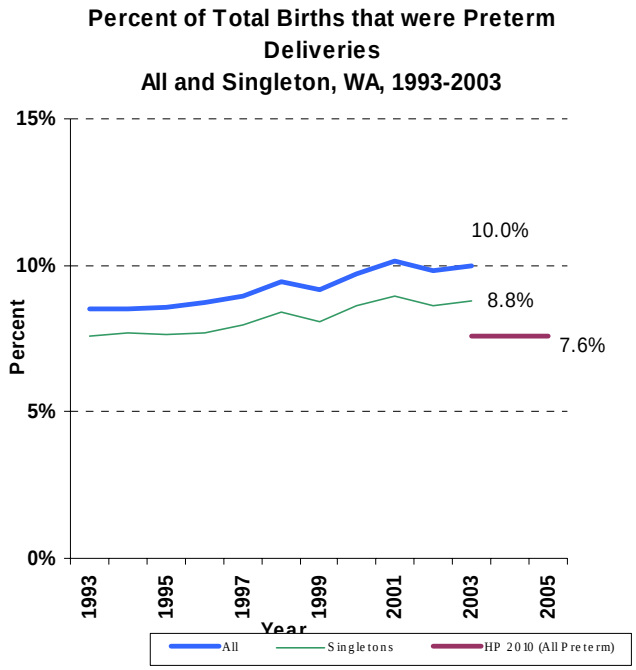
Percent of Singleton Preterm Deliveries by County* WA, 2001-2003



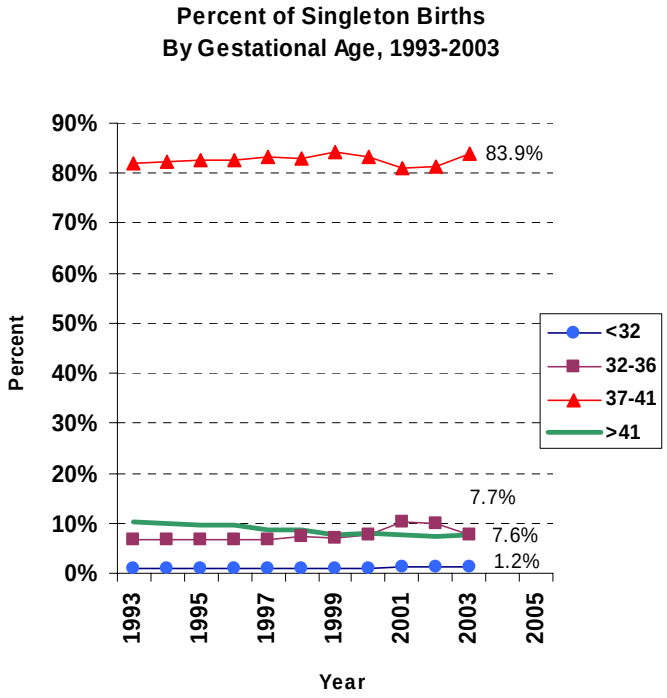
** County rate not calculated if fewer than 5 events*

Significantly different from state based on 95% confidence intervals

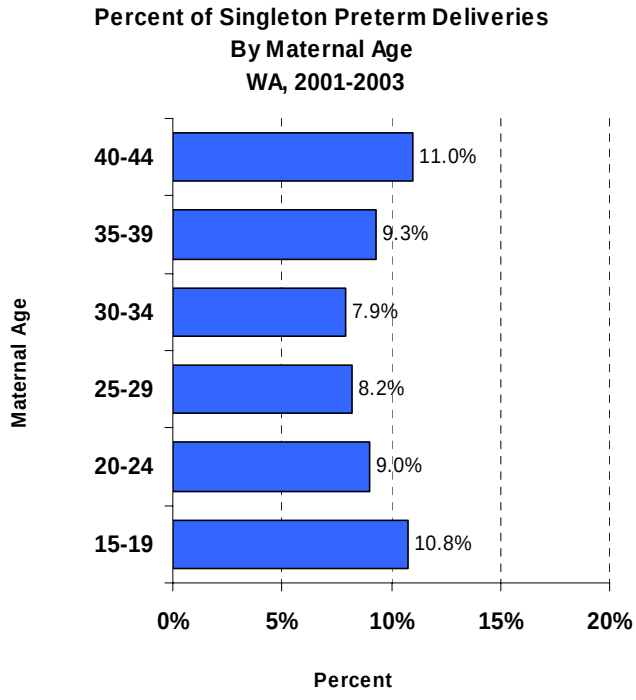
Time Trend [1, 4]



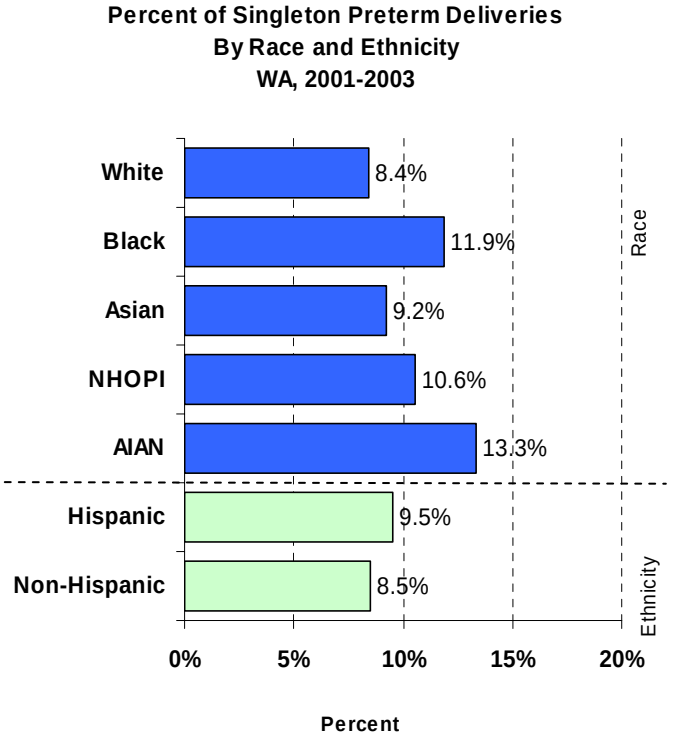
Time Trend by Gestational Age [1]



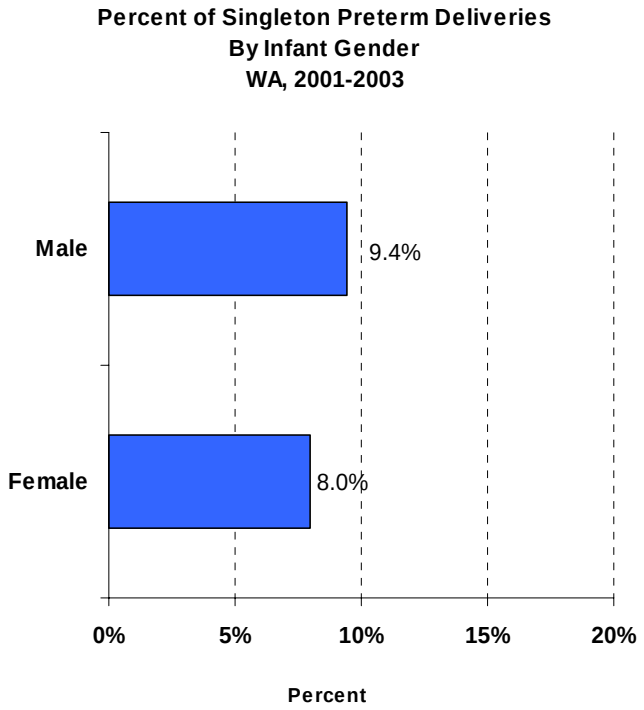
Age [1]



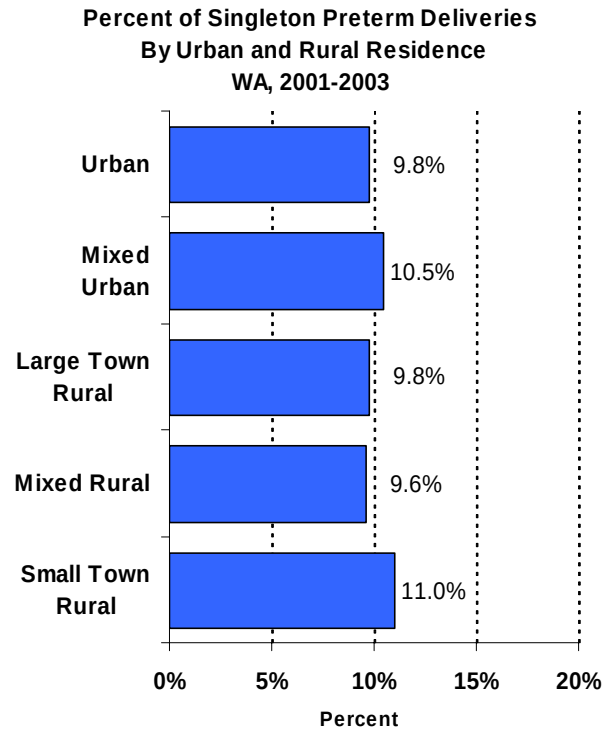
Race and Ethnicity [1,b,c]



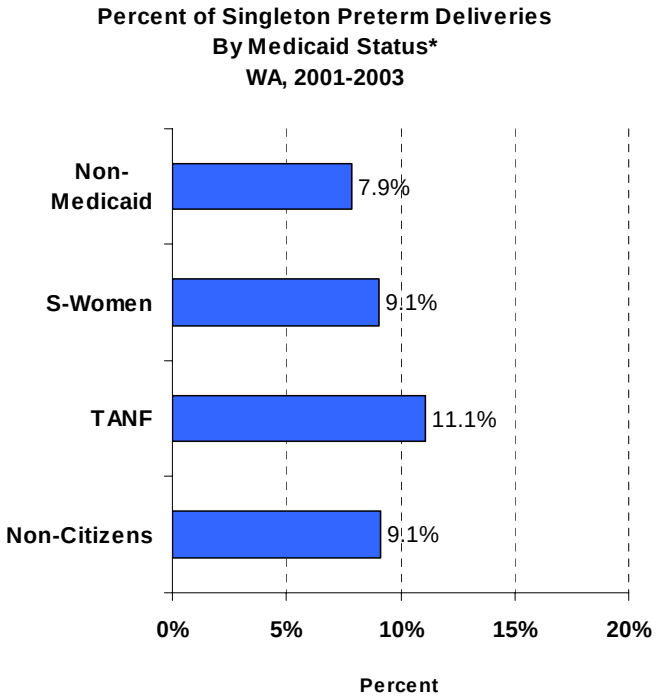
Infant Gender [1]



Rural and Urban Residence [5,d]



Medicaid Status [3]



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Data Sources

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2. Martin JA, Hamilton RE, Sutton PD, et al. Births: Final Data for 2003: National Vital Statistics reports ; Vol 54 No. 2, Hyattsville, MD: National Center for Health Statistics, 2005.
3. Cawthon, L. Preterm (<37 weeks) by Medicaid eligibility, for singleton live births with valid gestational age, 2001-2003, Washington State Department of Social and Health Services, First Steps Database, 5/10/05
4. Department of Health and Human Services (US). Healthy People 2010: Understanding and Improving Health. 2nd edition. Washington, DC: US Government Printing Office; November 2000.
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Endnotes

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c. NHOPI – Native Hawaiian/Other Pacific Islander
d. Rural urban differences are based on county level RUCA codes calculated using 2000 census data (see Technical Notes for description of RUCA codes)

Smoking During Pregnancy

Publicly funded services to address smoking are described in First Steps and Tobacco Services for Pregnant Women

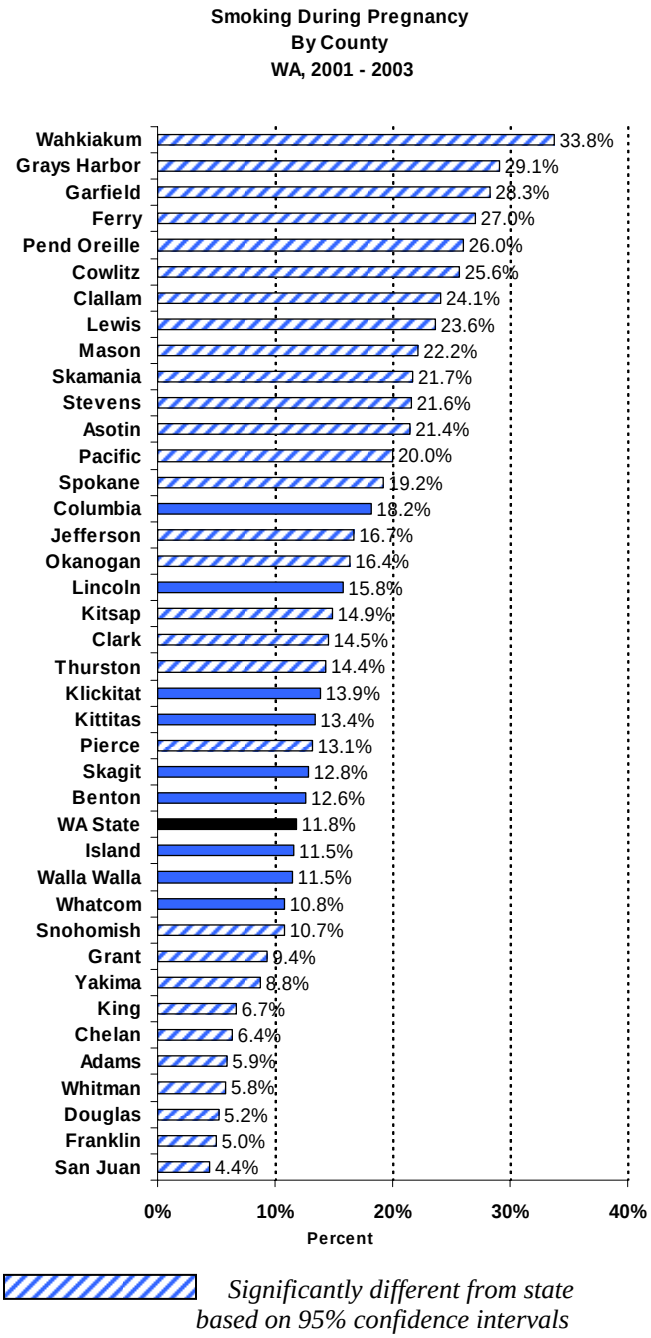
Key Findings:

- In 2003, the birth certificate question regarding smoking changed from "Yes/No" to the number of cigarettes smoked in the first, second, and third trimesters. Analysis comparing historical data to 2003 data, show that changes seen in 2003 are consistent with previous years' data.
- Tobacco smoking during pregnancy is the most important preventable cause of low birth weight. Smoking is also associated with spontaneous abortion. Tobacco smoking among women with live births in Washington State decreased significantly from 19.9% in 1992 to 10.8% in 2003. Nationally in 2003, 10.7% of women with live births smoked during pregnancy.[1,3]
- American Indian/Alaska Native women, Non-Hispanic women, and Native Hawaiian/Pacific Islander women were more likely to report smoking during pregnancy than women of other races/ethnicities.[1,a]
- Women on Medicaid, especially women receiving TANF were more likely to report smoking during pregnancy compared to Non-Medicaid women.[6]
- Smoking during pregnancy was highest among women 15-19 years of age and decreased with age until 35-39 years.[1]
- Among PRAMS respondents in 2001-2003, an estimated 21% reported smoking during the three months prior to pregnancy, 11% during the last three months of pregnancy and 15% postpartum. (Data not shown)[5]

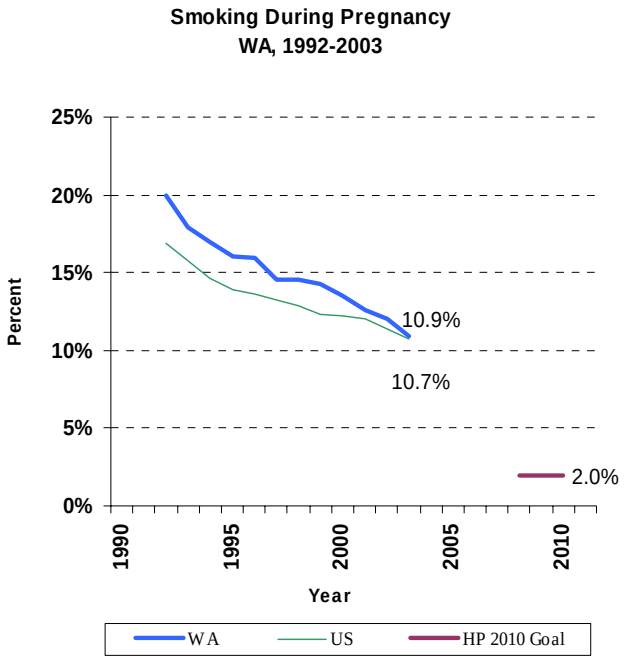
Definition: Smoking during pregnancy is defined as the mother smoking at any time during her pregnancy as reported on the Washington State Birth Certificate.

- The Healthy People 2010 goal is to increase abstinence from smoking among pregnant women to 99%, and to increase smoking cessation during the first trimester of pregnancy to 30%.[2]

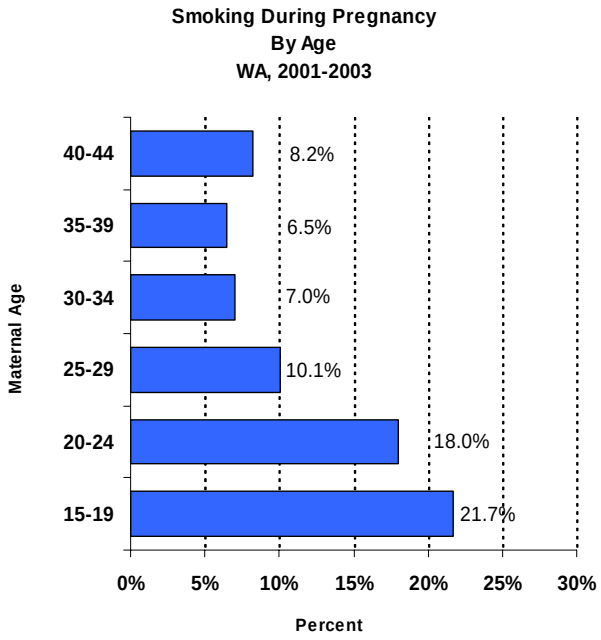
County [1,a,b]



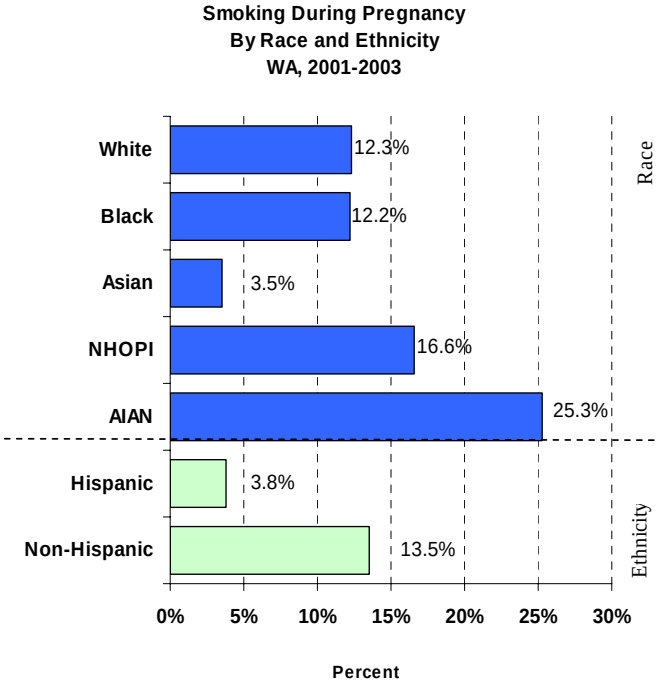
Trend [1,3,b]



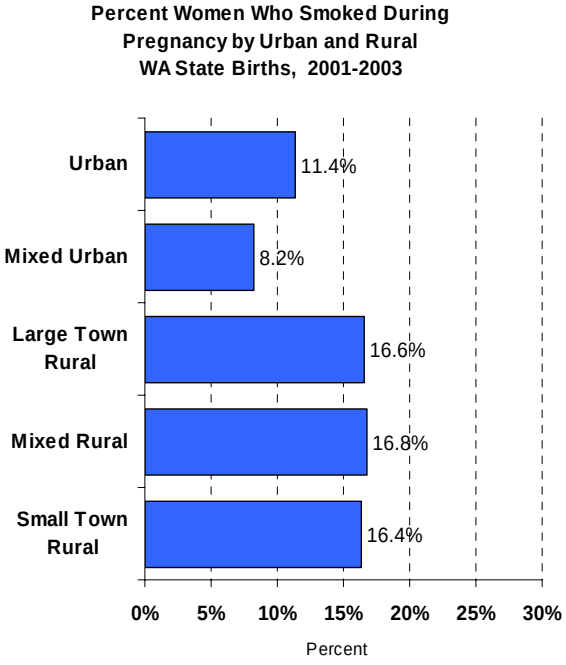
Age [1,b]



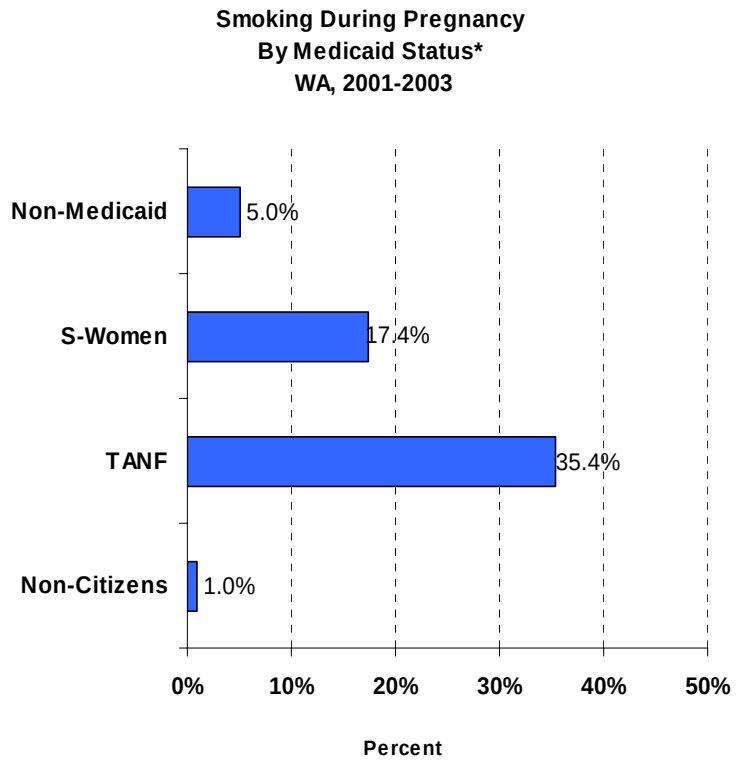
Race and Ethnicity [1,c,d,e]



Rural and Urban Residence [7,b,f]



Medicaid Status [5, b,c]



***** Medicaid women received maternity care paid for by Medicaid. They are divided into three major subgroups (from highest to lowest socioeconomic status): **S-Women** - those women who are citizens and eligible to receive Medicaid because they are pregnant and have incomes at or below 185% FPL, **TANF** - those women who are very low income (generally < 50% FPL) and receive cash assistance (TANF) in addition to Medicaid, and **Non-Citizens** - those women who are not citizens and are eligible to receive Medicaid because they are pregnant and have incomes at or below 185% FPL. Non-citizens are not eligible for TANF although their incomes are often lower than women on TANF. All three Medicaid groups have incomes below most Non-Medicaid women.

Data Sources

1. Washington State birth certificate data: Vital Statistics 2003, Washington State Department of Health, Center for health Statistics, December 2004.
2. Department of Health and Human Services (US). Healthy People 2010: Understanding and Improving health. 2nd edition. Washington, CD: US Government Printing Office; November 2000.
3. Martin JA, Hamilton BE, Sutton PD, et. Al. Births Final Data for 2003. National Vital Statistics Reports, Vol 54 No 2. Hyattsville, MD: National Center for Health Statistics, 2005. Website: http://www.cdc.gov/nchs/data/nvsr/nvsr54/nvsr54_02.pdf
4. Mathews TJ. Smoking during pregnancy in the 1990s. National Vital Statistics Reports, Vol 49 No 7. Hyattsville, MD: National Center for Health Statistics, 2001. Website: http://www.cdc.gov/nchs/data/nvsr/nvsr49/nvsr49_07.pdf
5. Washington Pregnancy Risk Assessment Monitoring System (PRAMS), 2001-2003.
6. Cawthon L. "Mother Smoked During Pregnancy, by Medicaid Eligibility Excluding Unknowns, for Mothers who gave birth 2001-2003 (Yes/No for 2001-2002, smoking during any trimester of pregnancy 2003". 5/10/05
7. Washington State Department of Health, Office of Community and Rural Health. November 2005.

Endnotes

a. Significance was determined based on 95% Confidence Intervals.
b. Data for the county-specific, age-specific, race and ethnicity, and rural-urban smoking rates are based on the percent of infants whose mothers smoked during pregnancy. Medicaid-specific rates show the percent of pregnant women who reported smoking. Slight differences exist between these two measures.
c. Includes fetal deaths and live births
d. AIAN – American Indian/Alaska Native
e. NHOPI – Native Hawaiian/Other Pacific Islander
f. Rural urban differences are based on county level RUCA codes calculated using 2000 census data (see Technical Notes for description of RUCA codes)

Special Health Care Needs & Disabilities

Publicly funded services to identify and address Special Health Care Needs and Disabilities are described in Care Coordination Services, Early and Periodic Screening, Diagnosis and Treatment, Family Support Services, Early Hearing Loss Detection, Diagnosis and Intervention, and Immunization Program CHILD Profile

Definitions:
Children with Special Health Care Needs: Children and youth with special health care needs are those who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who require health and related services of a type or amount beyond that required by children generally. (MCHB, 2001) [3]

Disabilities: Children having an activity limitation, who use assistance or perceive themselves as having a disability. (Healthy People 2010)

Key Findings:

Prevalence

Special Health Care Needs:

- Based on the 2003 National Survey of Children's Health, about 17% of children in Washington had a special health care need, compared to about 18% nationally. A significantly higher proportion of school-age children had a special health care need compared to children 0-4 years. This may be the result of improved identification when children enter school.
- No significant differences in the prevalence of CSHCN by gender, race, or poverty level were observed.[1]

Disabilities:

- In 2004, about 19% of Washington 8th graders and 23% of 10th and 12th graders reported that they had a disability. (Data not shown)[2]

Disparities among Youth with Disabilities

Disability and Substance Use:

- In 2004, Washington 10th graders with a disability were more than twice as likely to report cigarette smoking in the past 30 days compared with those without a disability.[2]
- In 2004, about 23% of Washington 10th graders with a disability reported using marijuana in the past 30 days compared to 15% of those without a disability.[2]
- In 2004, about 25% of Washington 10th graders with a disability reported binge drinking within the past two weeks compared to 18% of 10th graders without a disability.[2]

Violence

- Washington students with disabilities were more likely to report physical fighting in the past year (38%) compared to youth without disabilities (25%) and carrying a weapon at school (9%) compared to students without disabilities (4%).[2]

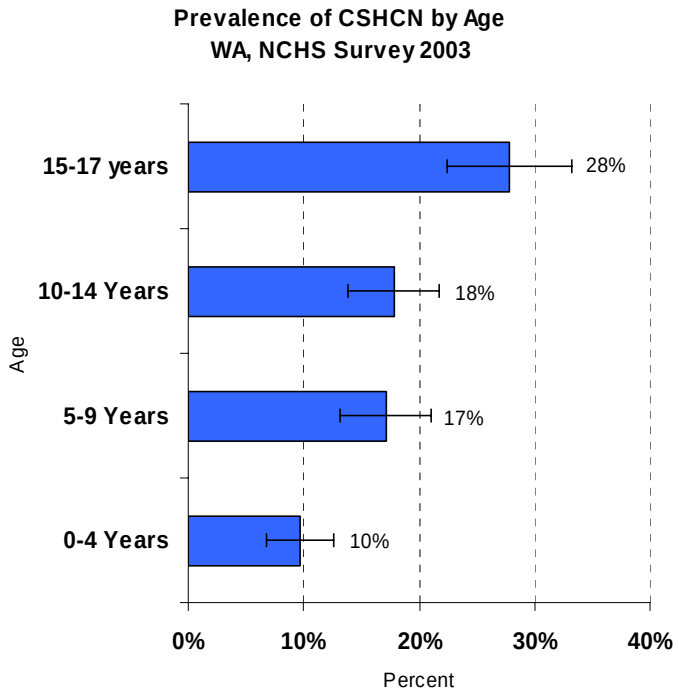
Access to Care:

- In Washington, youth with a disability were less likely to report a dental visit in the past year compared to youth without a disability. (Data not shown)[2]
- According to the 2003 National Survey of Children's Health, an estimated 54% of Washington's children with special health care needs received care within a medical home [c], compared to 52% of children without special health care needs. (Data not shown)[1]

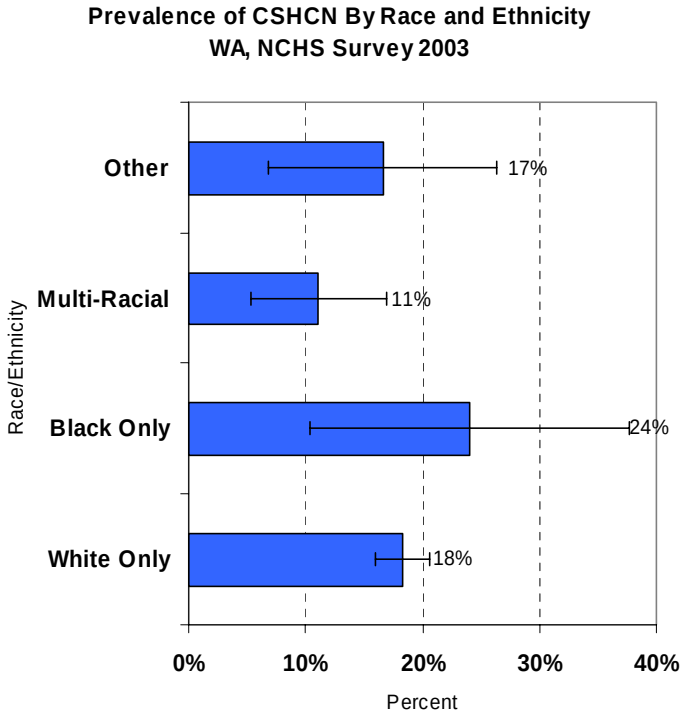
Rural Urban Differences

- Children with special health care needs living in suburban areas were the least likely to need routine preventive care (63%), while those in large towns were the least likely to need specialized therapies (16%) and the most likely to need substance abuse treatment (11%) compared to children with special health care needs living in other areas. (Data not shown).[3]

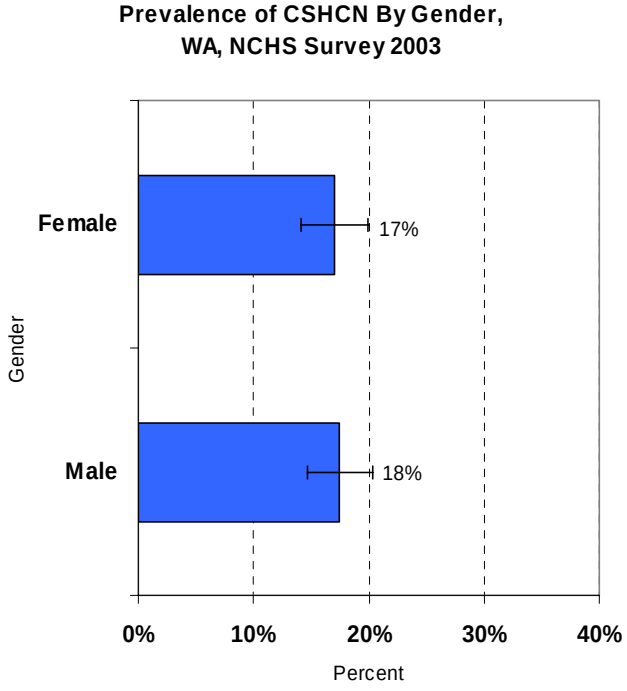
Age [1]



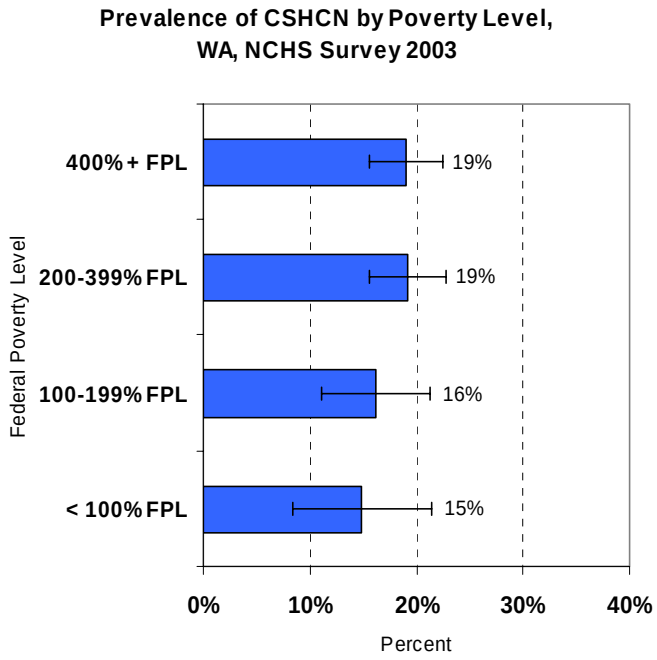
Race and Ethnicity [1]



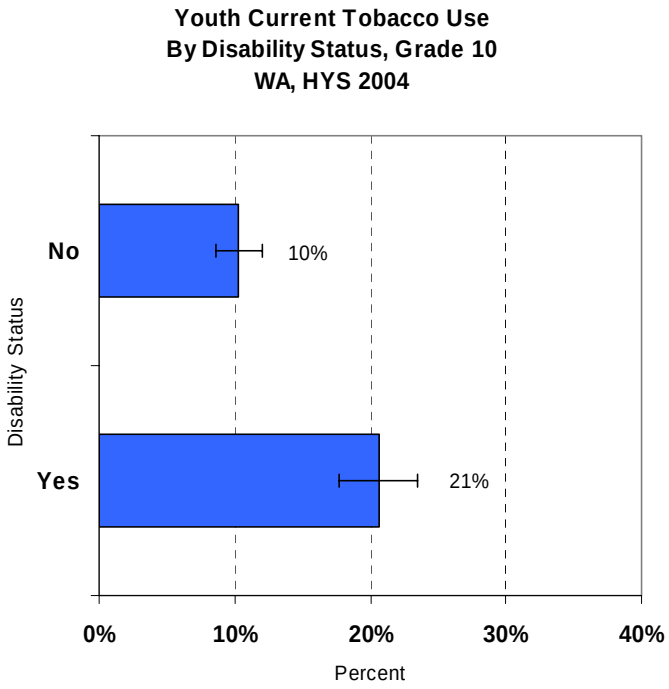
Gender [1]



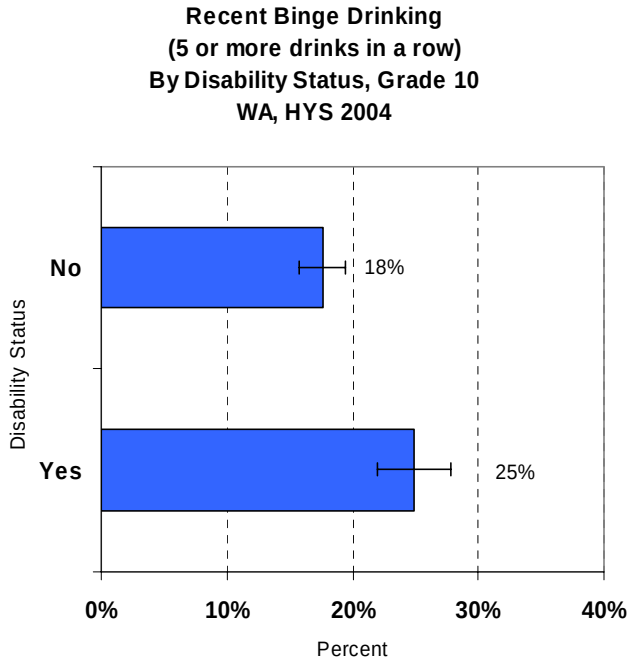
Poverty Level [1]



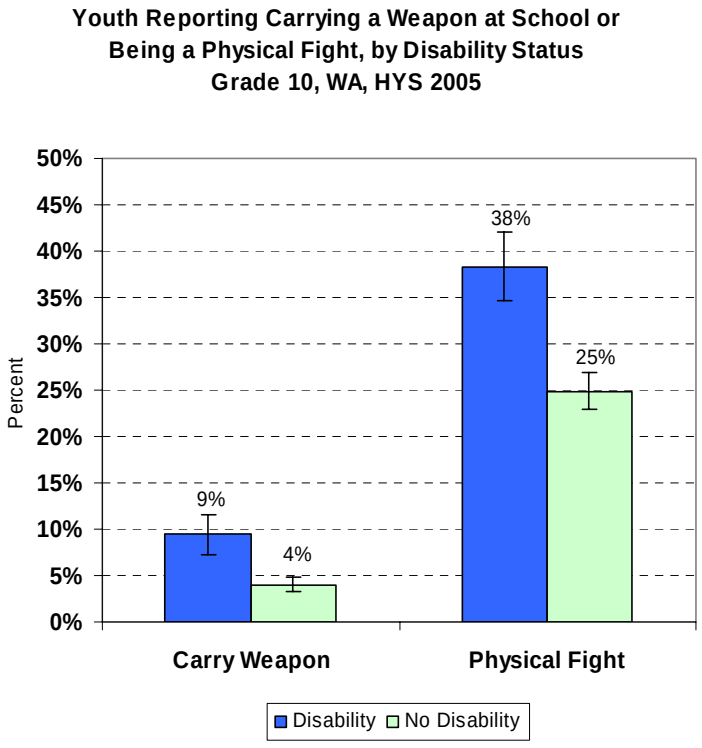
Tobacco Use [2]



Binge Drinking [2]



Violence [2]



Data Sources

1. 2003 National Survey of Children's Health, Department of Health and Human Services, CDC, National Center for Health Statistics, Hyattsville, Maryland.
2. Washington State Healthy Youth Survey 2004. Washington State Office of Superintendent of Public Instruction, Department of Health, Department of Social and Health Services, and Department of Community, Trade, and Economic
3. 2001 National Survey of CSHCN, Department of Health and Human Services, CDC, National Center for Health Statistics, Hyattsville, Maryland. Website: http://www.mchb.hrsa.gov/chscn/index.htm
4. 2003 American Community Survey (ACS), U.S Census Bureau.

Endnotes

a. Significance is based on 95% confidence intervals

b. Medical home: "An approach to providing health care services in a high-quality and cost-effective manner. Care is received from a pediatric health care profession whom the family trusts. Care is accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective. (American Academy of Pediatrics)

Substance Use in Adolescents

Publicly funded services to address Substance Use in Adolescents are described in Tobacco Prevention and Treatment for Youth, Substance Abuse Prevention and Treatment Services for Youth, and School-Based Health Centers.

Key Findings:

Tobacco Use

- In 2004, 2% of Washington 6th graders, 8% of 8th graders, 13% of 10th graders, and 20% of 12th graders reported current cigarette smoking. Cigarette smoking in adolescents peaked in 1995-1998 and has been dropping in recent years.[1,2]
- Regular tobacco use (tobacco use every day for the past 30 days) increases as students get older. Less than 1% of 6th graders, about 1% of 8th graders, 3% of 10th graders, and 6% of 12th graders report regular tobacco use. This is a dramatic decrease from 2002. (Data not shown).[2]
- The prevalence of smokeless tobacco use in 2004 was 1% of 6th graders, 2% of 8th graders, 5% of 10th graders, and 8% of 12th graders. Smokeless tobacco use declined among Washington youth throughout the mid to late-1990s, but remained constant from 2000-2004.[1,2]
- Washington appears to be meeting the Healthy People 2010 goal to reduce current cigarette use in students grades 9-12 to 16% or less, but is not meeting the goal to reduce current smokeless tobacco use to no more than 1%.[3]

Alcohol Use

- In 2004, an estimated 4% of 6th graders, 18% of 8th graders, 33% of 10th graders, and 43% of 12th graders used alcohol in the past 30 days. Except for 6th grade, there is no statistically significant difference in alcohol use by gender.[2]

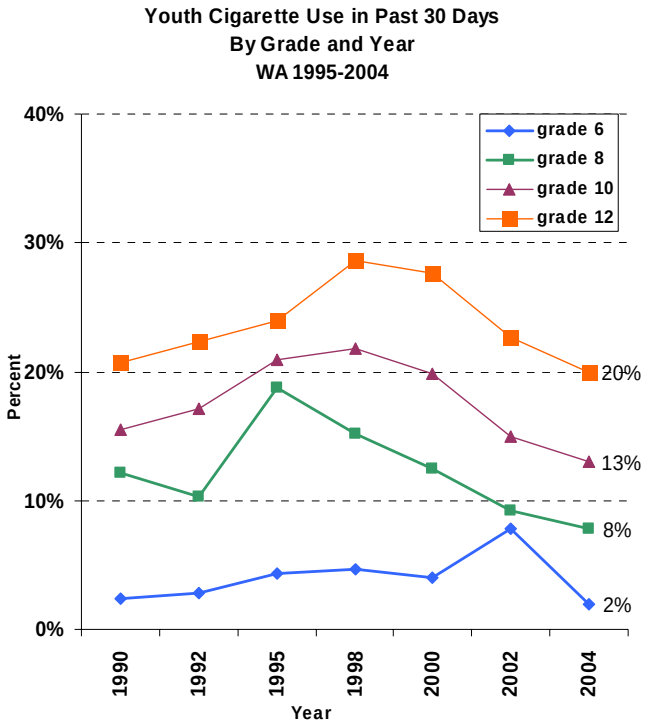
Definition: Current substance use refers to use of alcohol, tobacco, or other illicit substances on one or more of the past 30 days.

- In 2004, about 10% of 8th graders, 19% of 10th graders, and 26% of 12th graders reported binge drinking (drinking 5 or more alcoholic beverages in a row) in the past two weeks.[2]
- Washington is not yet meeting the Healthy People 2010 objectives to reduce adolescents' binge drinking in the past month to 2.0%, and to reduce binge drinking during the past two weeks among high school seniors to no more than 11%.[3]

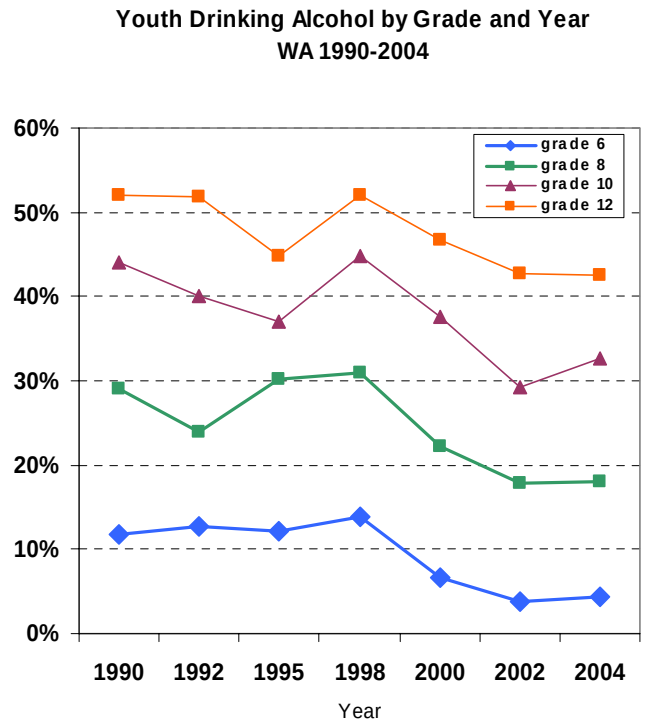
Illicit Substance Use

- In 2004, about 2% of 6th graders, 9% of 8th graders, 17% of 10th graders, and 20% of 12th graders reported using marijuana in the past 30 days.[2]
- Between 2% and 8% of students reported ever using methamphetamine, cocaine, steroids, or ecstasy in their lifetime. For example, about 3% of 8th graders, 5% of 10th graders, and 6% of 12th graders reported ever using methamphetamine. About 3% of 8th graders, 6% of 10th graders, and 8% of 12th graders reported ever using cocaine. (Data not shown)[2]
- Students who report smoking tobacco are more likely to also report using other drugs. For instance, in 10th grade about 38% of smokers reported using marijuana in the past 30 days compared to 4% of non-smokers.[2]
- Washington is not yet meeting the Healthy People 2010 objectives to increase the proportion of adolescents not using alcohol or any illicit drugs during the past 30 days to 89%; and to reduce the proportion of adolescents using marijuana to 0.7%. [3]

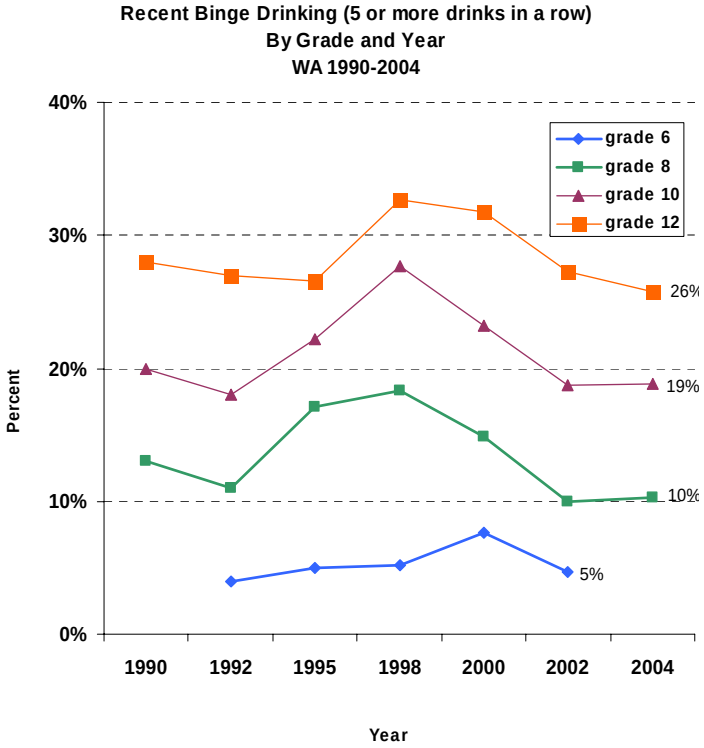
Cigarette Smoking [1,2]



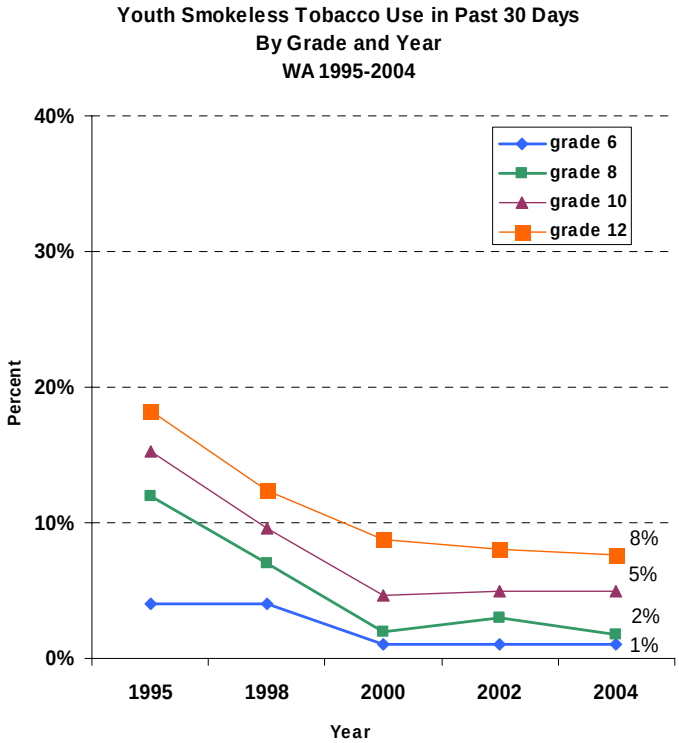
Drinking [1,2]



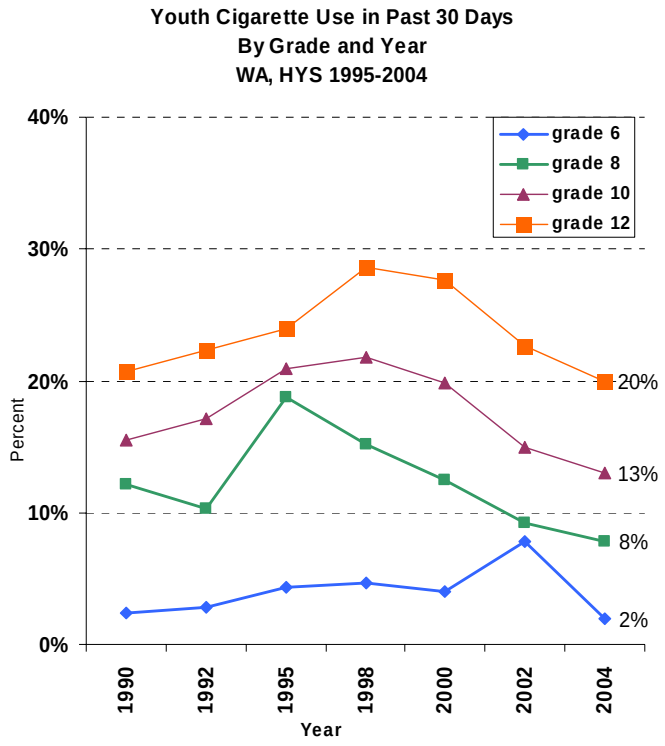
Binge Drinking [1,2]



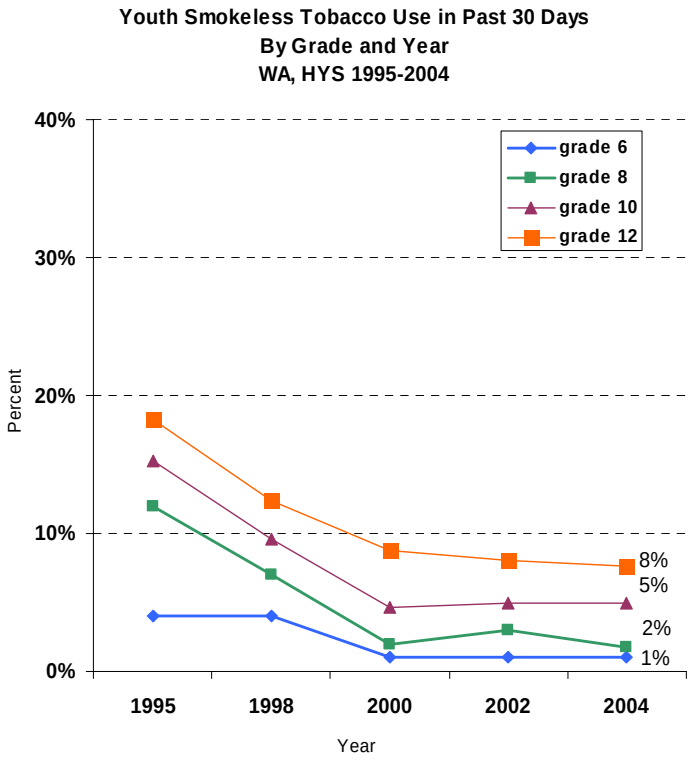
Smokeless Tobacco Use [1,2]



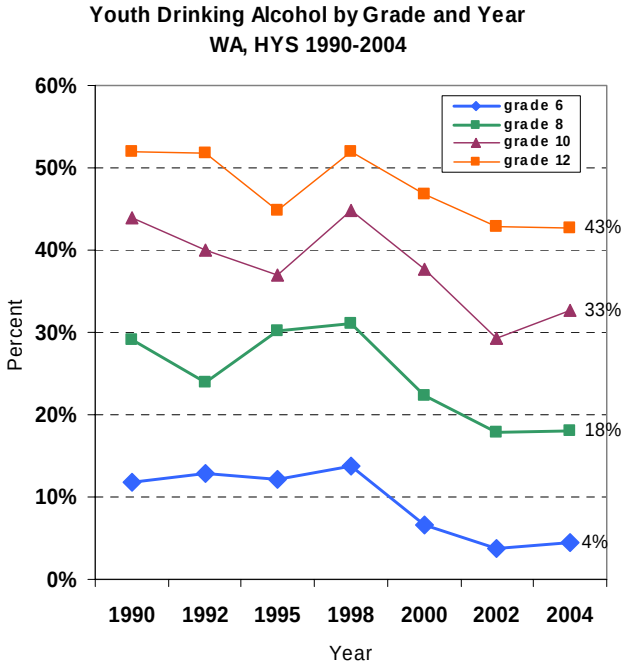
Cigarette Smoking [1,2]



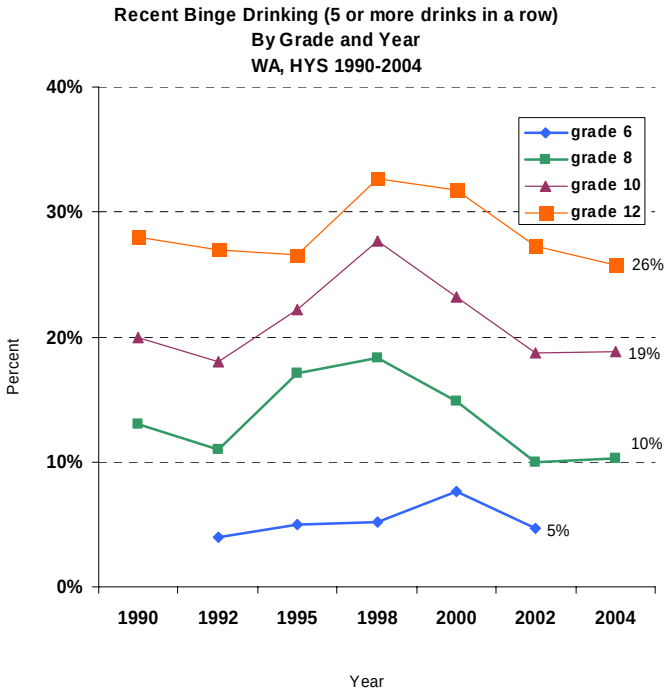
Smokeless Tobacco Use [1,2]



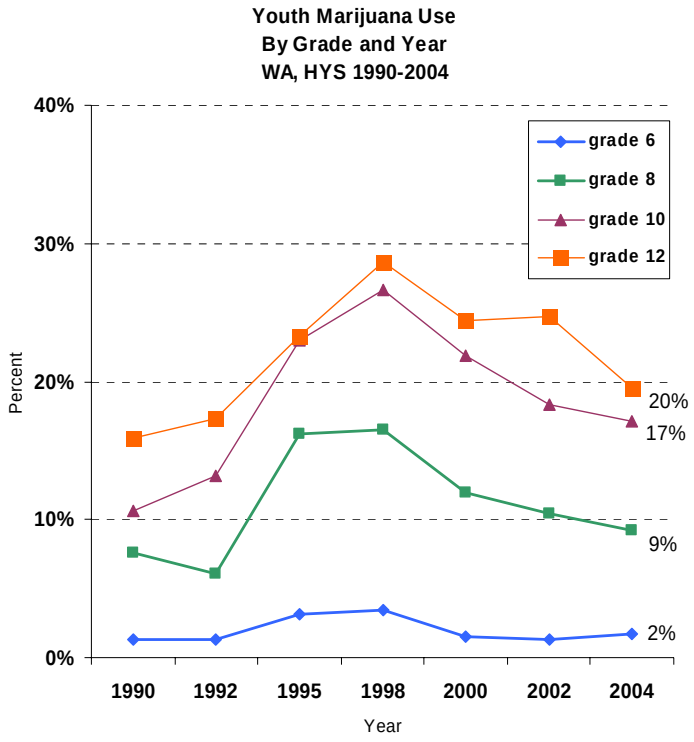
Drinking [1,2]



Binge Drinking [1,2]



Marijuana Use [1,2]



Data Sources

1. Washington State Survey of Adolescent Health Behaviors 1992, 1995, 1998, 2000; Washington State Drug and Alcohol Survey, 1990.
2. Washington State Healthy Youth Survey 2002 & 2004. Washington State Office of Superintendent of Public Instruction, Department of Health, Department of Social and Health Services, and Department of Community, Trade, and Economic Development and RMC Research Corporation. Website: http://www3.doh.wa.gov/HYS/ASPX/HYSQuery.aspx
3. Department of Health and Human Services (US). Healthy People 2010: Understanding and Improving Health. 2nd edition. Washington, DC: US Government Printing Office; November 2000.
4. Washington State Youth Risk Behavior Survey, 1999.

Unintended Pregnancy

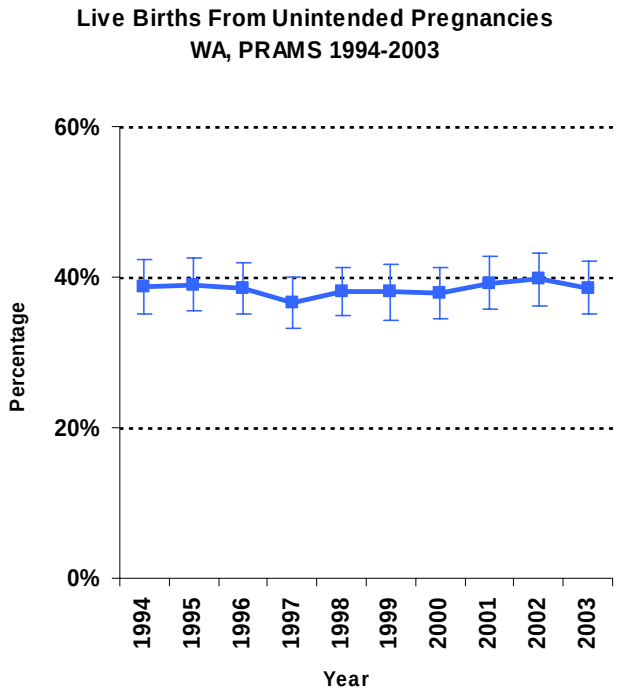
Publicly funded services to address Unintended Pregnancy are described in Family Planning and Teen Pregnancy Prevention

Definition: Unintended pregnancy is the retrospective report of intention to become pregnant by women 2-6 months after giving birth. It refers to pregnancies that were mistimed (for example, mother wanted them to occur "later") or unwanted at the time of conception. Unintended pregnancy is measured as [[(Estimated percentage of unintended pregnancies from PRAMS)*(resident live births)] + (reported resident abortions)] divided by [resident live births + reported resident abortions].

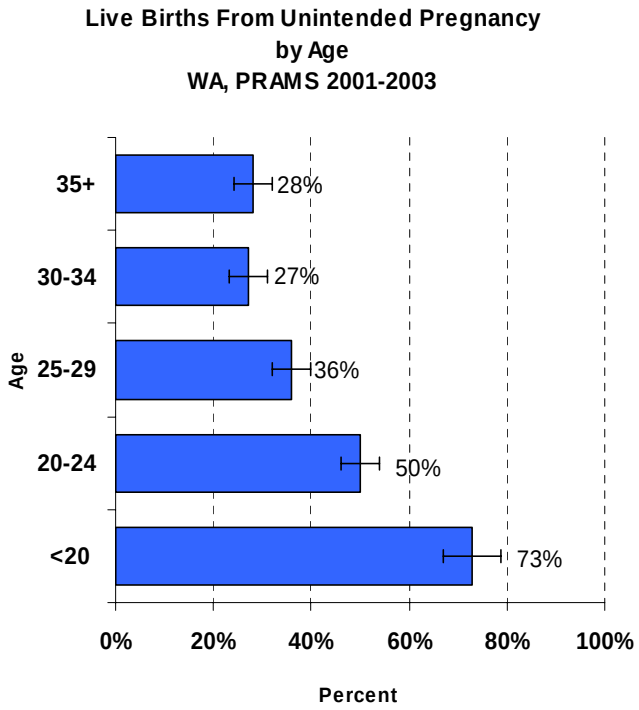
Key Findings:

- Unintended pregnancy is an ambiguous concept that is imperfectly measured. Pregnancy intention may vary depending on when in relation to the pregnancy it is collected and the concept of intending or planning pregnancies may be influenced by cultural perceptions. In Washington, data on pregnancy intention is collected from women who have delivered live births. Women who avoid unintended pregnancies are excluded from this measure, potentially influencing the results. Trends in teen birth rates illustrate this dilemma: for Washington teens < 20 years, the birth rate decreased by 33% from 47.1 per 1000 in 1996 to 31.5 per 1000 in 2003. During the same period the percent of births from unintended pregnancies in PRAMS remained essentially unchanged. For these reasons, we are exploring other measures and whether we should continue the current data collection method.
- From 2001-2003, an estimated 54% of all pregnancies in Washington State were unintended, and an estimated 39% of live births were from unintended pregnancies. The proportion of live births from unintended pregnancies in Washington has not changed significantly since data collection began in 1994.[1,2]
- The proportion of live births from unintended pregnancies varies significantly by age. About 73% of births to women less than 20 years of age were reported as births from unintended pregnancies. This rate decreases with age, but remains sizable even among older women. The lowest rate is among women 30-34 years who report an estimated 27% of births were from unintended pregnancies.[2,a]
- Black women and American Indian/Alaska Native women were significantly more likely to report their birth was from an unintended pregnancy compared to Asian, White, and Hispanic women.[2,a]
- TANF recipients were significantly more likely to report their delivery was from an unintended pregnancy than other Medicaid or Non-Medicaid women.[2,a]
- Washington has not yet met the Healthy People 2010 objective to increase pregnancies that are intended to 70%.[3]

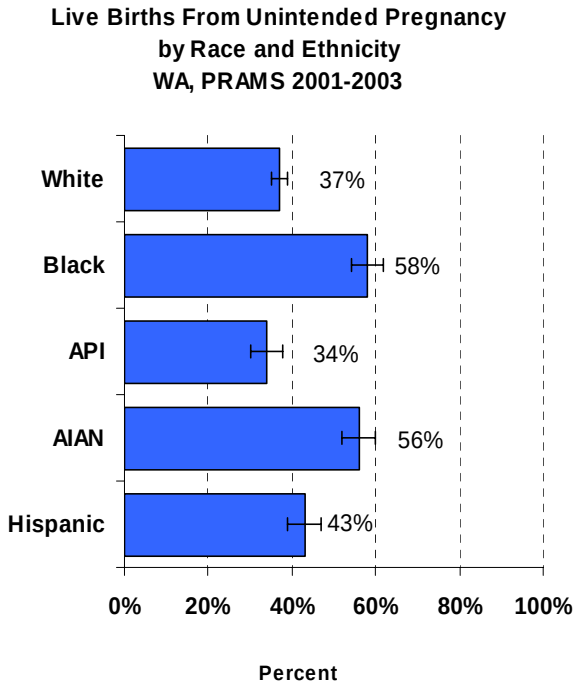
Time Trend [2,a]



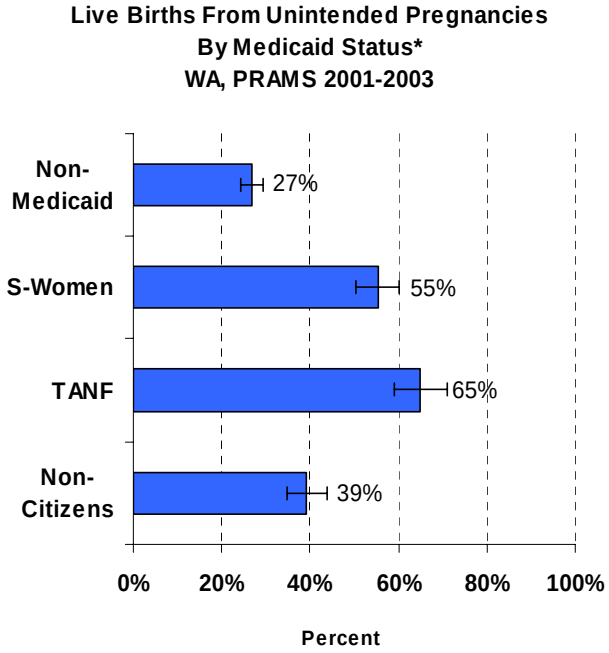
Age [2,a]



Race and Ethnicity [2,a,b,c]



Medicaid Status [2,3,a,d]



Data Sources

1. Washington State Pregnancy and Induced Abortion Statistics 2003, Center for Health Statistics, 2005.
2. Washington Pregnancy Risk Assessment Monitoring System (PRAMS), 2001-2003. Washington State Department of Health, 2005.
3. First Steps Database. Research and Data Analysis Division, Washington State Department of Social and Health Services, 2005.
4. Department of Health and Human Services (US). Healthy People 2010: Understanding and Improving Health. 2nd edition. Washington, DC: US Government Printing Office; November 2000.

Endnotes

a. Significance was determined based on 95% Confidence Intervals
b. AIAN – American Indian/Alaska Native
c. API – Asian or Pacific Islander
d. Medicaid women received maternity care paid for by Medicaid. They are divided into three major subgroups (from highest to lowest socioeconomic status): **S-Women** - those women who are citizens and eligible to receive Medicaid because they are pregnant and have incomes at or below 185% FPL, **TANF** - those women who are very low income (generally < 50% FPL) and receive cash assistance (TANF) in addition to Medicaid, and **Non-Citizens** - those women who are not citizens and are eligible to receive Medicaid because they are pregnant and have incomes at or below 185% FPL. Non-citizens are not eligible for TANF although their incomes are often lower than women on TANF. All three Medicaid groups have incomes below most Non-Medicaid women.

Unintentional Injury: Mortality and Hospitalizations

Publicly funded services to address Unintentional Injury in the MCH population are described in Immunization Program CHILD Profile. In addition the DOH Injury Program addresses unintentional injury.

Key Findings:

Mortality

- In 2003, there were 201 deaths due to unintentional injury (UI) for Washington state residents ages 0-19. The UI death rate for Washington children ages 0-19 decreased from 35.0 per 100,000 in 1980 to 11.9 per 100,000 in 2003. Deaths due to motor vehicle crashes, which are the leading cause of unintentional injury deaths in children, decreased from 20.4 per 100,000 Washington children ages 0-19 in 1980 to 7.2 per 100,000 in 2003.
- Among Washington children ages 0-19, unintentional injury death rates are highest in males, American Indian/Alaska Natives, infants, and adolescents ages 15-19 years.
- While the leading causes of unintentional injury deaths vary by age of the child, the leading causes for all Washington residents ages 0-19 are motor vehicle traffic, drowning, and suffocation.
- The Healthy People 2010 goal is to reduce the UI death rate for the whole population to no more than 17.5 per 100,000 population and motor vehicle crashes to no more than 9.2 deaths per 100,000 population.

Definitions:
Unintentional injury deaths: Include those deaths due to accidental causes.[a]

Unintentional injury hospitalizations: Nonfatal hospitalizations due to unintentional injuries (ICD-9 codes E800-E869 and E880-E929). They include adverse effects, which are injuries related to therapeutic use of drugs and adverse effects of medical and surgical care. Unintentional injury hospitalizations include the primary diagnosis only. The data source is the Washington State Comprehensive Hospital Abstract Reporting System (CHARS). Patients hospitalized more than once with the same diagnosis will be counted as separate incidents.

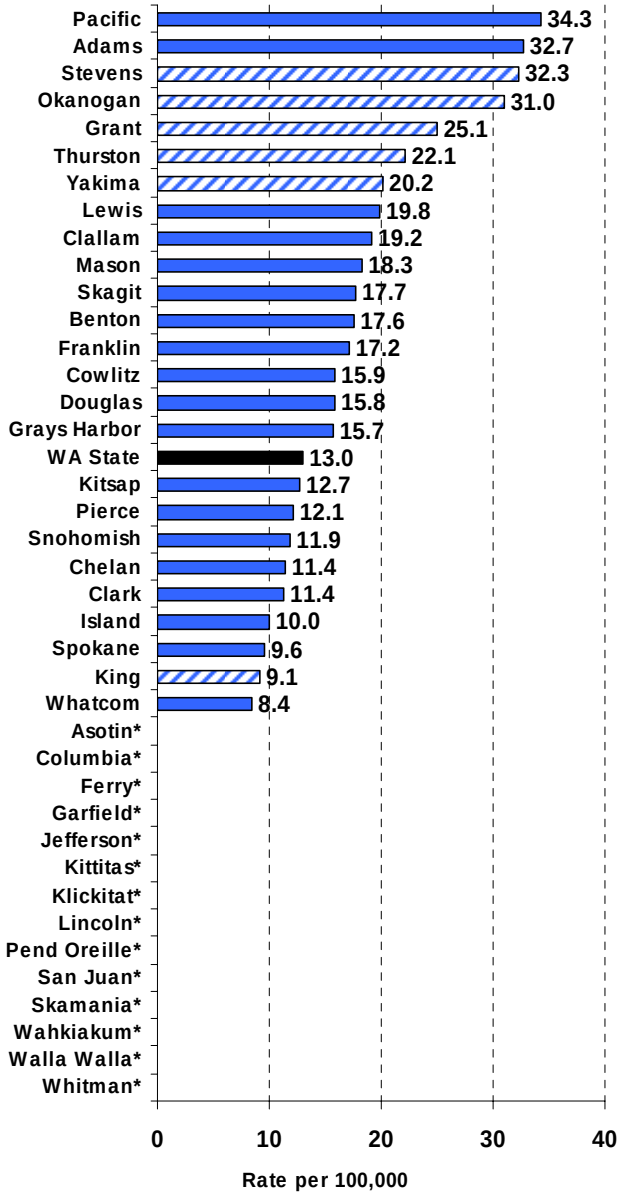
Hospitalizations

- There were 3,087 nonfatal unintentional injury (UI) hospitalizations for Washington children ages 0-19 in 2003, for a rate of 182.0 per 100,000. This represents a 49% decrease from the 1990 rate of 355 per 100,000.
- The highest UI hospitalization rates for Washington children were in infants less than 1 year old and children ages 15-19. Males ages 0-19 had significantly higher UI hospitalization rates than females.
- Washington children in small town rural areas had significantly higher unintentional injury hospitalization rates than children in other areas.
- While the leading causes of unintentional injury hospitalization vary by age, overall the three most common causes for UI hospitalizations for Washington children were falls/jumps/pushes, motor vehicle transport, and struck by or against (which includes injuries caused by being accidentally struck by an object or person).

Mortality

County [1,2]

Unintentional Injury Death Rate, Age 0-19
By County
Per 100,000, WA, 2001-2003

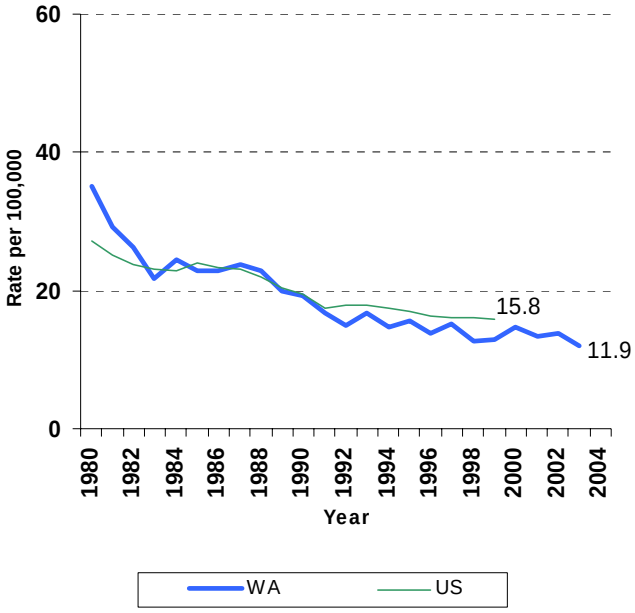


**County rates not calculated if less than 5 events*

Significantly different from state based on 95% confidence intervals

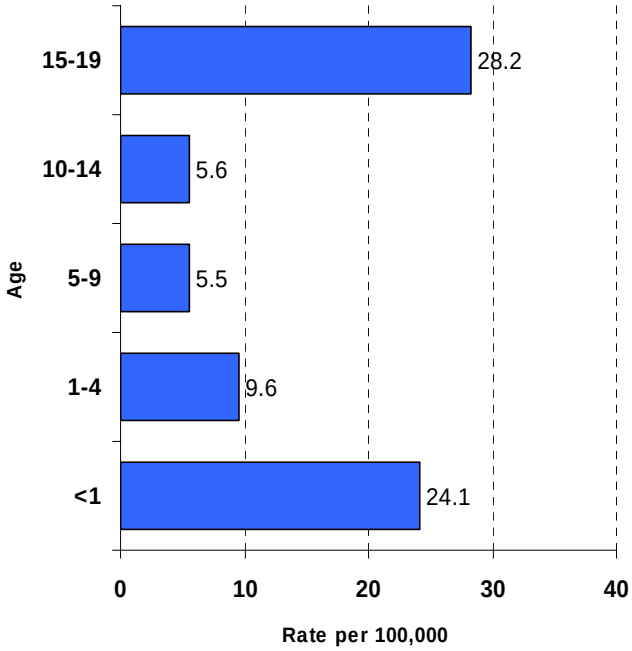
Time Trend [1,2]

Unintentional Injury Death Rate
Ages 0-19, By Year
WA State and US, 1980-2003



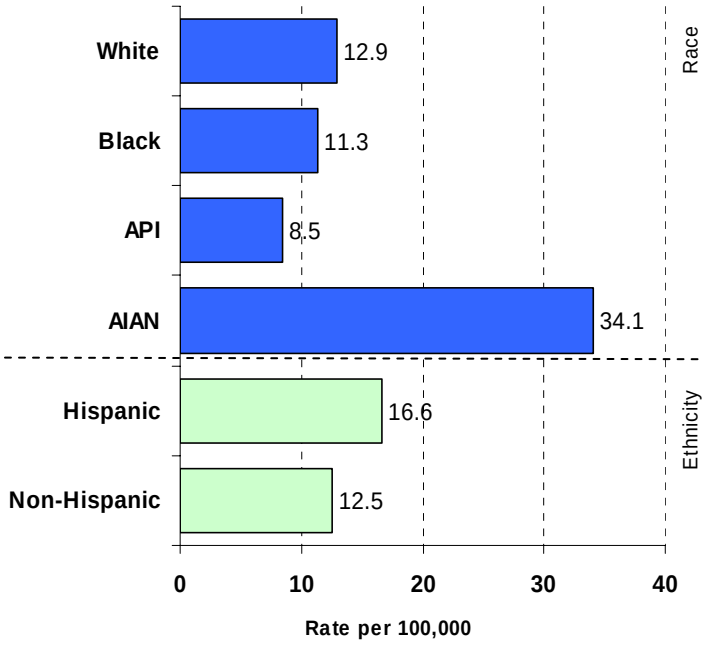
Age [1,2]

Unintentional Injury Death Rate
By Age
Per 100,000, WA, 2001-2003



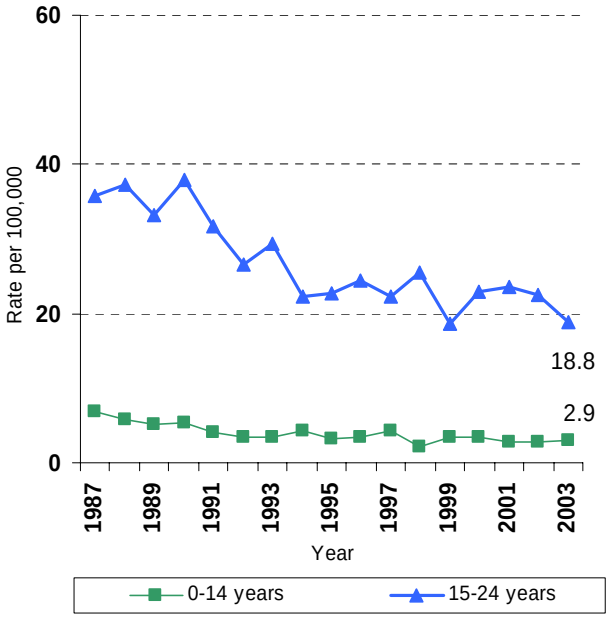
Race and Ethnicity [1,2,c,d,e]

Unintentional Injury Death Rate, Ages 0-19
By Race and Ethnicity
Per 100,000, WA, 2001-2003



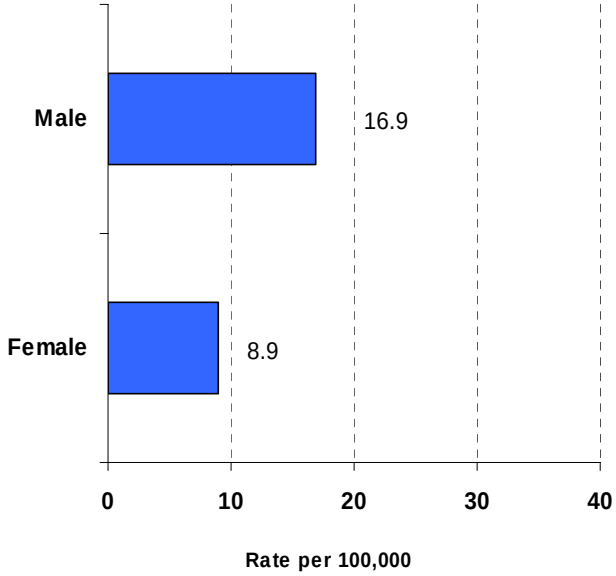
Block Grant Measure: Motor Vehicle Crashes [1,2]

Motor Vehicle Crash Death Rate
By Age Groups
Per 100,000, WA, 1987-2003



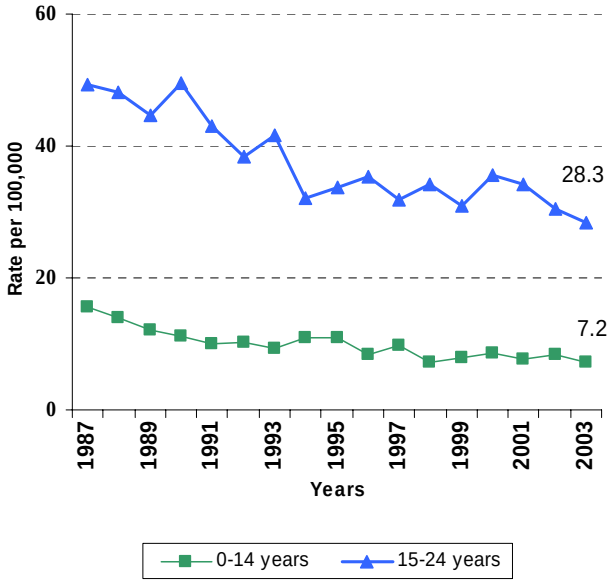
Gender [1,2]

Unintentional Injury Death Rate, Age 0-19
By Gender
Per 100,000, WA, 2001-2003



Time Trend by Age [1,2]

Unintentional Injury Death Rate
By Age Groups
Per 100,000, WA, 1987-2003

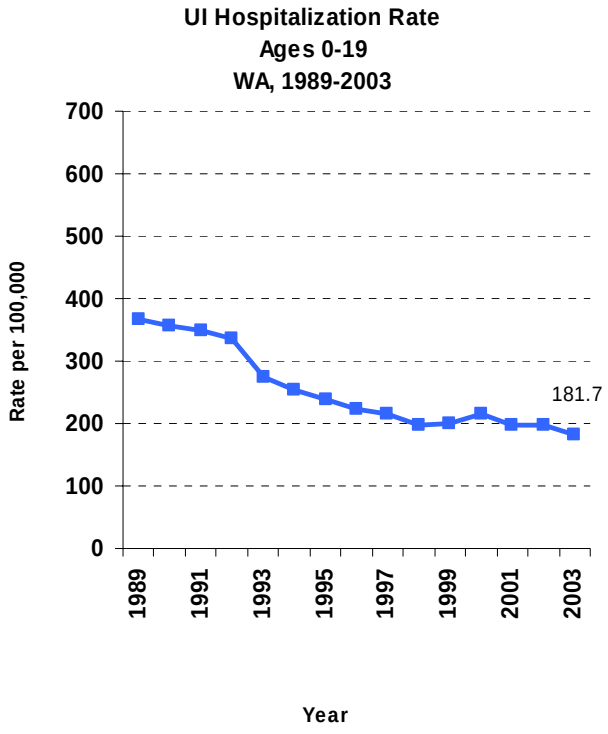


Leading Causes of Unintentional Injury Deaths, 1999-2003
WA Children Ages 0-19, by Age Group [3]

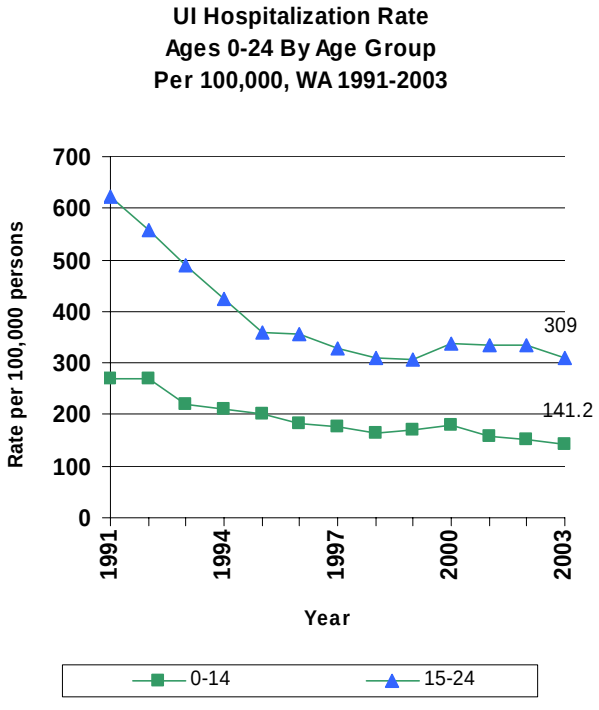
Rank	<1	1-4	5-9	10-14	15-19
1st	Suffocation & obstruction (N=53)	Drowning (N=39)	MVT, occupant (N=44) [f]	MVT, occupant (N=41) [f]	MVT, occupant (N=402) [f]
2nd	MVT, occupant (N=14) [f]	MVT, occupant (N=33) [f]	Drowning (N=17)	Drowning (N=30)	Drowning (N=57)
3rd	Fire/Flame/Hot Object (N=5)	Fire/Flame/Hot Object (N=18)	MVT, pedestrian (N=13)	Suffocation & Obstruction (N=11)	Poisoning (N=36)
4th	Drowning (N=4)	Suffocation & Obstruction (N=17)	Fire/Flame/Hot Object (N=7)	MVT, pedestrian (N=11) [f]	MVT, pedestrian (N=24) [f]

Hospitalizations
(Non-Fatal Injuries) [g, i]

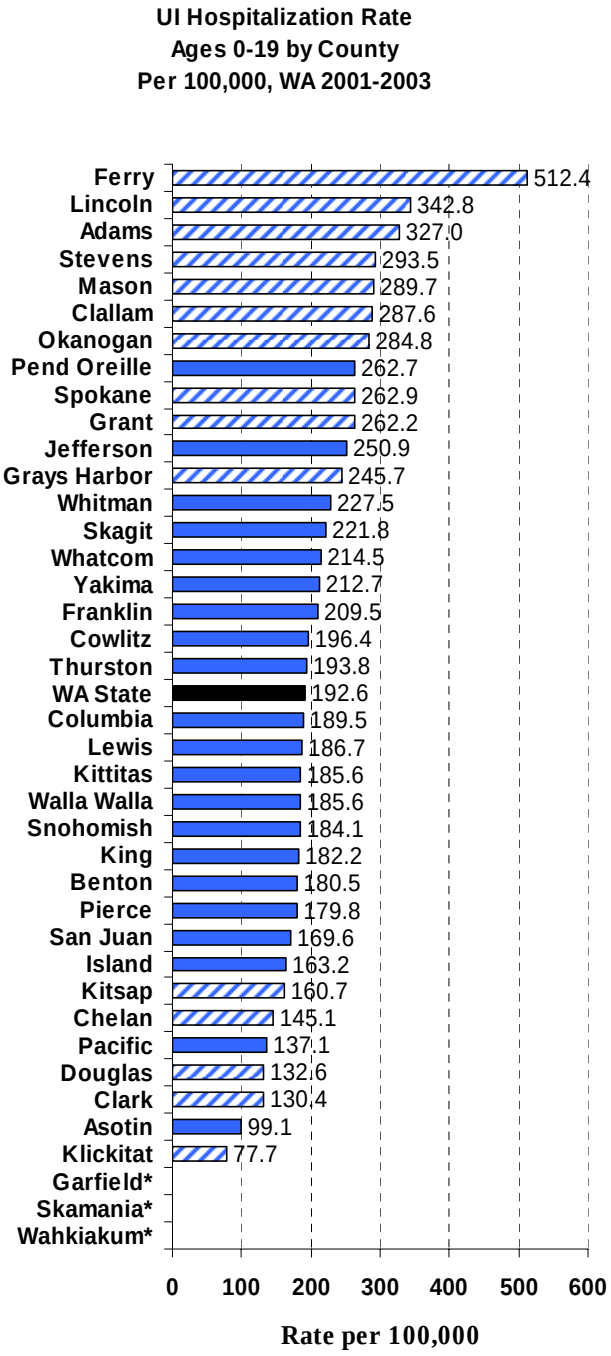
Time Trend [6,i]



Block Grant Measure: Unintentional Injury 0 to 24 year olds [6,i]



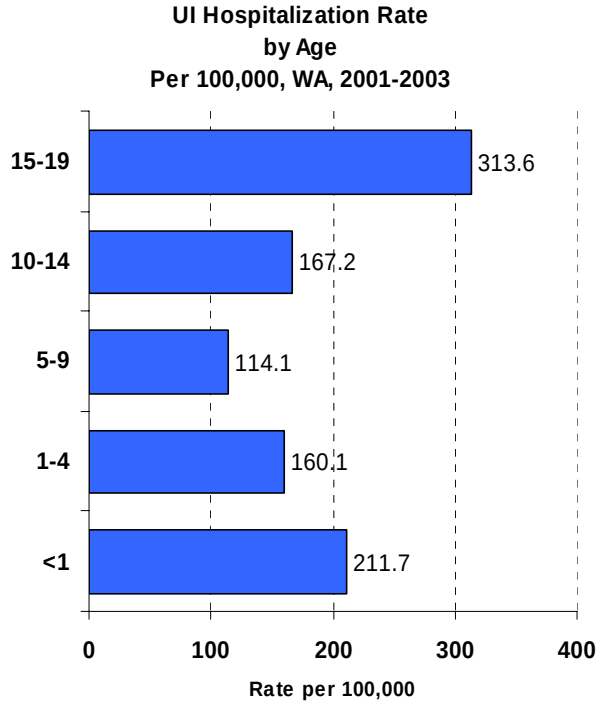
County [6,i]



**County rates not calculated if less than 5 events*

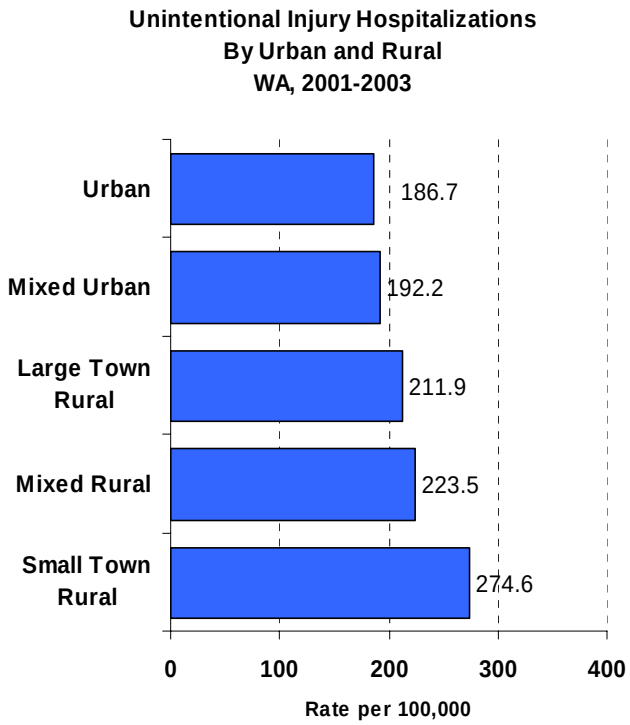
Significantly different from state based on 95% confidence intervals

Age [6,i]

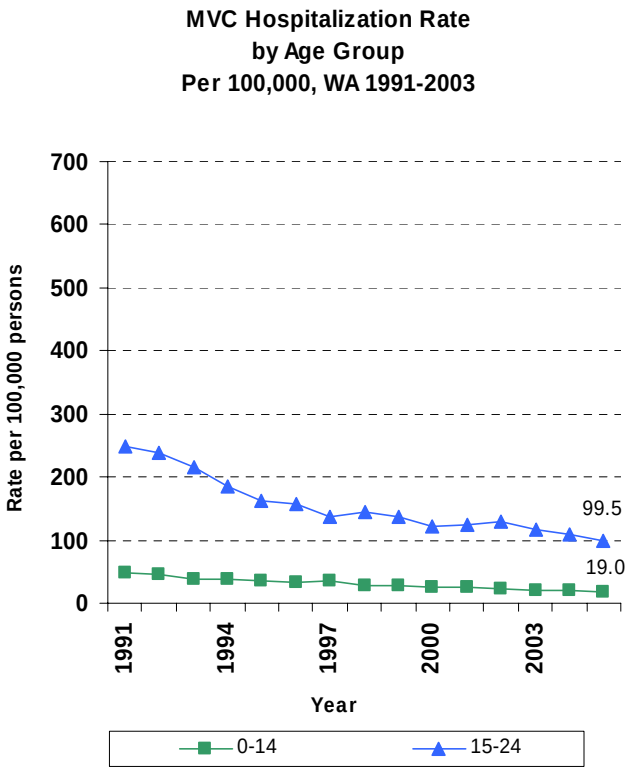


Gender [6,i]

Rural and Urban Residence [7,h,i]



Motor Vehicle Crashes (MVC) [6,i]



Leading Causes of Unintentional Injury Hospitalizations, 2001-2003
WA Children Ages 0-19, by Age Group [6,i]

Rank	<1	1-4	5-9	10-14	15-19
1st	Fall/Jump/Push	Fall/Jump/Push	Fall/Jump/Push	Fall/Jump/Push	Motor Vehicle Transport
2nd	Poisoning	Hot Object/Substance	Motor Vehicle Transport	Motor Vehicle Transport	Fall/Jump/Push
3rd	Suffocation	Poisoning	Pedal Cyclist, Other	**Other Land Transport* **Struck by (or against)*	Struck by or against

** In age group 10-14, categories Other Land Transport and Struck by or against are tied for 3rd place in the rankings*

Data sources

1. Washington State death certificate data: Vital Statistics 2003, Washington State Department of Health, Center for Health Statistics, March 2005
2. Analysis Software: Public Health – Seattle & King County, Epidemiology, Planning & Evaluation, Software for Public Health Assessment (VistaPHw), 1991-.
3. Washington State Department of Health, Center for Health Statistics, Death Records – April 2005 release. Website: http://www.doh.wa.gov/cfh/Injury/data_tables/by_age/fatal/FatalByAge_WashingtonState.pdf
4. Data from the Washington State Child Death Review Database, MCH Assessment Section, Washington State Department of Health, 1999-2001.
5. Healthy People 2010: Understanding and Improving Health, US Department of Health and Human Services, Washington DC US Government Printing Office, 2000.
6. Comprehensive Hospital Abstract Reporting System (CHARS), Washington State Department of Health, Center for Health Statistics. August 2005 release.
7. Washington State Department of Health, Office of Community and Rural Health, November 2005.

Endnotes

a. The ICD-10 codes for unintentional injury deaths used from 1999 to the present include V01-X59 and Y85-Y86. The ICD-9 codes used prior to 1999 include E800-E869 and E880-E929. Comparability ratio (used to enable comparison)
b. Significance was determined based on 95% Confidence Intervals.
c. Population denominators for non-Hispanics are estimated by subtracting the number of Hispanics from the total population and may include unknowns.
d. AIAN – American Indian/Alaska Native
e. NHOPI – Native Hawaiian Other Pacific Islander
f. MVT – Motor Vehicle Transportation
g. See "Technical Notes" for details regarding hospitalization data
h. Rural urban differences are based on county level RUCA codes calculated using 2000 census data (see Technical Notes for description of RUCA codes)
i. Graphs reflect non-fatal injury hospitalizations

Access to Primary Care Providers

Overview

- Both the Washington State Department of Health and the Washington State Department of Social and Health Services are concerned with promoting adequate access to health care across Washington.
- The Office of Community and Rural Health (OCRH) at the Washington State Department of Health connects communities and resources to develop access to care and sustainable health care systems across the state. OCRH works with local health jurisdictions to assess the need for providers locally, and provides technical assistance to providers and facilities on federal grants, health professional support programs, and health facility support programs. OCRH Website: http://www.doh.wa.gov/hsqa/ocrh
- OCRH has worked with individual local health jurisdictions to conduct provider surveys to assess direct care provided by primary care providers in several local health jurisdictions. This work has often been part of efforts related to Health Professional Shortage Area and Medically Underserved Area designations. Surveys are voluntary but have experienced excellent response rates (95% or better). Surveys can provide a good indication of access to primary care within counties, and taken as a group may indicate system-wide issues.
- The Health and Recovery Services Administration (HRSA) at the Washington State Department of Social and Health Services has an Access Measurement Workgroup which has been monitoring access to care for Medical Assistance eligible clients. Analyses are based on claims data for fee-for-service clients. About 27% of Medicaid children were covered by Medicaid fee-for-service in 2003.[1]
- HRSA Access Website: http://fortress.wa.gov/dshs/maa/Access/ProviderAccess/
- Currently, there is no comprehensive statewide database to assess access to health care providers across Washington. Assessing access is further complicated by the varied mix of payer types across the state, and the limitations on access by payer type.

Structure of the Primary Care Delivery System

- Primary care services are delivered by providers in private practice, as part of health maintenance organizations (HMO), at Federally Qualified Health Centers (primarily for uninsured and underinsured individuals), and at Rural Health Clinics, Tribal Centers and in residency programs. *(See Safety Net Services section for a description of Federally Qualified Health Centers, Rural Health Clinics, Tribal Centers and Residency Programs)*
- This structure of primary care services varies across counties in Washington. The distribution of the population that is uninsured, publicly insured and privately insured also varies, as does the proportion in managed care. Consequently, issues with access to care vary across Washington.[2]

[1] DSHS Human Services in Your County, July 2002-June 2003, Washington State Department of Social and Health Services, Research and Data Analysis Division. Accessed from http://www1.dshs.wa.gov/excel/ms/rda/2003/state.xls 6/01/05.

[2] Schueler V. Access to Primary Care and Other Healthcare Services in Washington: Recent Results. Washington State Department of Health, Office of Community and Rural Health, November 19, 2004.

Data Sources and Measures

- OCRH has used two primary measures to monitor access to primary care: the number of primary care physician full time equivalencies (FTEs) and the physician FTE to population ratio. The physician FTEs takes the number of primary care physicians identified through provider surveys and adjusts for part-time hours and hours not spent in direct patient care (1FTE=40 hours of direct patient care/week). Primary care includes family practice, obstetrics and gynecology, general internal medicine and pediatrics. These two measures are stratified by the payer type, by urban/rural status, and calculated for new and existing clients.
- HRSA Access Measurement Workgroup has used three measures to monitor access to care for its fee-for-service population. These measures include the number of active providers, the ratio of providers to 1000 clients, and the proportion of clients being served by the top quartile of active providers. ("Active Providers" is the number of physicians or Advanced Registered Nurse Practitioners (ARNPs) that had at least one patient visit in a given time period.) Two additional measures will be added in future reports: the ratio of the number of fee-for-service visits per 1000 active physicians, and the number of visits per 1000 eligible fee-for-service clients. HRSA presents data for primary care providers (including general practice, family practice, pediatrics and internal medicine) and specialty providers.
- Several differences in measurement make comparisons across the information from these two offices difficult. These differences include: definition of primary care providers (i.e., which specialties are included and whether mid-level providers are included); client population (Fee-for-service Medicaid clients vs. total county population); source of information (billing data vs. provider self-report); time frame (quarters of year vs. time of surveys across several years) and geographic scope (statewide vs. aggregation of county-specific surveys which excludes out-of-county services).

Trends from OCRH Investigations:

- Primary care capacity in urban areas appears to be declining slowly while it is improving slowly in rural areas.
- Many counties are showing stress in their overall primary care provider capacity (>2000 population: 1 provider): Okanogan (Tonasket only), Clallam, Clark, Grant, Grays Harbor, Kitsap, Mason, Snohomish, and Whatcom (Note: This is not an exhaustive list as not all counties have been surveyed).
- Stressed counties are more likely to be rural Western Washington counties (especially those with a limited safety net capacity), urban counties with a limited safety net capacity and counties with rapidly growing Hispanic populations.
- Primary care provider capacity for low-income population is somewhat worse than overall capacity.
- Access for new clients is difficult, especially in urban counties and for publicly funded clients. Among 7 urban counties combined, only 24% of primary care physicians reported accepting new Medicaid fee-for-service clients without restrictions.
- Counties with strong primary care provision through safety net providers (such as Federally Qualified Health Centers, Rural Health Centers and primary care residency programs) are more likely to have better access for new patients compared to counties with providers primarily in private practice.

- Capacity to serve the uninsured is very limited almost everywhere.

Trends from HRSA Access Measurement Workgroup Investigations[3,4,5]

- Statewide, the number of active fee-for-service providers has been increasing about 3.0% per year since 1998.
- Statewide, the ratio of active fee-for-service primary care providers per 1000 clients increased 9.8% from 18.4 per 1000 in CY 2003 to 20.2 per 1000 in CY 2004. This increase was observed in 27 of 39 Washington counties.
- The top quartile of primary care providers saw 69% of the fee-for-service office visits over the last four years. This measure monitors the distribution of services by providers. If services were evenly distributed across providers, the top quartile of providers would see 25% of the office visits.
- Access to obstetric care:
    - The number of physicians delivering Medicaid fee-for-service clients did not decrease from SFY 2000-2003.
    - The number of deliveries per provider increased over this time period, which is consistent with trends in the number of Medicaid-paid deliveries and changes in the proportion of women enrolled in fee-for-service.

Issues

- Statewide assessment of access to care is not possible due to the lack of a database with all primary care providers in Washington, and lack of common measures for monitoring access to providers.
- Data currently available on access is not specific to Maternal and Child Health populations; most notably, children with special health care needs, pregnant women, women of reproductive age, and teens.
- Data currently available on access focus on the geographic availability of providers and availability by payer type. Other components of access, such as provider hours, accessibility of provider offices to people with disabilities, wait times, and languages spoken by provider and staff are not addressed.

[3] Health and Recovery Services Administration Fee-For-Service Physican and ARNP Participation, SFY 2004 Update. Washington State Department of Social and Health Services, Health and Recovery Services Administration, 2005.
http://fortress.wa.gov/dshs/maa/Access/ProviderAccess/SFY2004PreliminaryUpdateFinal.pdf

[4] Measuring Fee-For-Service Physican and ARNP Participation and Client Access To Care – Baseline Measures. Washington State Department of Social and Health Services, Health and Recovery Services Administration, 2004.
http://fortress.wa.gov/dshs/maa/Access/ProviderAccess/Phase1ReportFinal.pdf

[5] Health and Recovery Services Administration Fee-For-Service Physican and ARNP Participation, CY 2004 Update. Washington State Department of Social and Health Services, Health and Recovery Services Administration, 2005.

Care Coordination Services

What is the service?

The American Academy of Pediatrics[1] defines care coordination as a collaborative process that links children and families to services and resources in a coordinated manner to maximize the potential of children and provide them optimal health care.

The role of care coordinators in Washington State public agencies is to coordinate and connect the supports, services, and resources for children and parents at home, child care, school, and other community settings such as medical providers and managed care plans. Providers include Local Health Departments, Neurodevelopmental or Developmental Disability Centers, Regional Offices in each of the six Department of Social and Health Services (DSHS) Regions, schools, Regional Support Networks for mental health services, medical providers, managed care plans, and many others. Care Coordinators may also be parents who help other parents become Care Coordinators for their child.

Ideally, a care coordinator would be the single point of entry to facilitate services across a variety of health and educational systems. But, because the number and variety of issues facing families is so unique and the service delivery system is complex with funding from multiple sources, we now have situations where there may be more than one care coordinator for a child and family. Every situation is unique and different, and each care coordinator may address one or more type of need for the child and family. See also the *Family Support* chapter for additional services offered by peer support organizations.

How/where is the service provided?

Local Health Departments

- Children with Special Health Care Needs (CSHCN) Coordinators are public health nurses located in local health departments across the state.
- CSHCN Coordinators help families access needed services for their children ages birth to 18 such as medical care and other interventions; refer families to health insurance programs, provide screening, and conduct assessment.

Local Contractors of the Infant and Toddler Early Intervention Program (ITEIP)

- Throughout the state, Family Resources Coordinators (FRC) provide service coordination activities for children birth to three. Each FRC has demonstrated knowledge and understanding about infants and toddlers eligible under Individuals with Disabilities Education Act (IDEA), Part C, the regulations in Part C 34, CFR Part 303, the nature and scope of services available under Washington State's Infant Toddler Early Intervention Program (ITEIP), the system of payment for services in Washington State programs, and other pertinent information.

[1] Pediatrics Vol.104 No. 4 October 1999, 978-981.

- The FRC is responsible for:
    1. Coordinating all services across agency lines.
    2. Serving as a single point of contact in helping parents to obtain the services and assistance they need.
    3. Assisting parents in gaining access to early intervention services and other services identified in the Individual Family Service Plan (IFSP).
    4. Coordinating the provision of early intervention services and other services that the child needs or receives.
    5. Facilitating the timely delivery of available services, and continuously seeking appropriate services and situations necessary to benefit the development of each child served for the duration of the child's eligibility.

Regional Offices in each of the six DSHS Regions and outstations in the Regions

- Division of Developmental Disabilities (DDD) Case Resource Managers determine eligibility for services, identify needs, and develop, monitor, and coordinate service plans. This person also authorizes payments for division services and other services available though the Aging and Disabilities Services Administration.

- The DDD Case Resource Manager is responsible for:
    1. Determining eligibility for DDD services.
    2. Doing needs assessments.
    3. Developing a Plan of Care for people with DDD waivers.
    4. Completing a Mini Assessment (by 2006) on people eligible for DDD but receiving no paid service.
    5. Completing a Full Assessment (by 2007) on all people receiving DDD service.
    6. Authorizing services via Social Services Payment System.
    7. Monitoring and coordinating authorized services.
    8. Providing resource information and referral services for clients birth through adulthood.
    9. Participating in County Interagency Coordinating Council efforts.

Schools

- School Nurses provide case management for students in her/his case load and interact with parents, providers, community, and school resources to provide a school environment that is safe, healthy, and conducive to learning.

- Case management of children with special health care needs involves activities designed to ensure the health and educational success of the child at school. It is the position of the National Association of School Nurses that school nurses have knowledge, experience and authority to be the case manager for children with special health care needs. This includes, but is not limited to:
    1. Having knowledge about services needed by students with special health care needs, after collaboration with student, family and health care provider.

2. Having knowledge about community services and assisting families in obtaining needed services.
3. Screening for students who would qualify and benefit from case management services for their health care needs.
4. Providing leadership in interdisciplinary team meetings to assist in planning needed services to meet the health and educational needs of the students.
5. Implementing the health team's care plan by providing direct or indirect care.
6. Coordinating continuity of care between home and school.
7. Monitoring and evaluating interventions and implementation of the health care plan.
8. Monitoring and evaluating progress toward health and educational goals.
9. Training, monitoring, and evaluating personnel delegated to perform specific nursing care.

Regional Support Networks

- Mental Health Rehabilitation services are integrated treatment services recommended by a mental health professional and provided by state licensed Community Mental Health Agencies. Services are provided to seriously mentally ill adults and seriously emotionally disturbed children for whom the services are determined to be medically necessary. These services must be provided to reach the goals of an Individualized Service Plan.

Medical Homes

- A Medical Home is an approach for providing health care and community services in a coordinated way. It is not a place. It's a relationship with a group of doctors, nurses, and other health care providers who know the children and their families. Medical Homes include pediatrician offices, family practice offices, or clinics that provide or arrange for care coordination for children with special health care needs. In a Medical Home, a child's health care provider knows and respects the child and the family, understands the child's needs, provides routine care like regular checkups and immunizations, works as an equal partner with families to make decisions about the child's health, and helps to coordinate the child's health care.
- **Tools to help organize a child's health information**
    1. Children's Hospital and Regional Medical Center's Care Notebook
    2. Mary Bridge Children's Hospital Care Notebook
    3. Los Angeles Medical Home Project Parent Notebook *(available in Spanish)*
    4. Washington State Medical Home website: http://www.medicalhome.org
- **Find community resources**
    1. Starting Point Resource Guide – Washington State
    2. Washington State County Resource Guides
- **Information about financial planning for children with special health care needs**
    1. American Academy of Pediatrics Future and Estate Planning

2. Exceptional Parent Magazine Life Planning

- **Preparing for a child's visit to the doctor**
  1. Bright Futures for Families - Materials
  2. "Building Early Intervention Partnerships With Your Child's Doctors: Tips from and for Parents (WA State Infant toddler Early Intervention Program, Department of Social and Health Services).

Who is receiving the Service?

(Note: The following programs are not mutually exclusive. Numbers should not be added together.)

CSHCN Programs in Local Health Departments
Number of Clients (0-18) in Washington State, 2004

	# clients[2]
Total Number of Children Served	10,185

Infant and Toddler Early Intervention Program (ITEIP)
Number of Children (0-3) in Washington State, October 2003- September 2004

	# clients [3]
Total Number of Children Served	6,806

Developmental Disabilities, 2004
Number of Children (0-17) in Washington State, July 2002 – June 2003

	# clients [4]
Total Number of Children Served	16,225

Regional Support Network, 2004
Number of Children (0-17) in Washington State, July 2002 – June 2003

	# clients [4]
Total Number of Children Served	37,175

[2] Child Health Intake Form (CHIF) statewide database, Washington State Department of Health, CSHCN Program, 2004.
[3] Infant and Toddler Early Intervention Program (ITEIP) data, October 2003-September 2004.
[4] DSHS Human Services in Your County, July 2002 – June 2003. Research and Data Analysis Division. Washington State Department of Social and Health Services, 2005. Available at http://www1.dshs.wa.gov/pdf/ms/rda/clientdata/03state.pdf

Schools in Class I Districts

The 66 Class I districts indicate the number of identified cases of specific health conditions. Additionally, these districts report the number of each specific health condition considered life-threatening per RCW 28A 210.320. This information is another data source pointing to the number and severity of health conditions present in school districts across the state. For the 2003-04 school year, the 66 Class I districts reported the following data:[5]

Disease/Condition	Number of Diagnosed Cases	Percent of Student Population	Number of Life-Threatening Cases	Percent of Diagnosed Cases Considered Life-Threatening
Asthma	28,836	5.2	2,314	8
Diabetes	1,394	0.2	1,204	86
Severe Allergies	7,765	1.4	4,199	54
Heart Conditions	1,866	0.3	262	14
Seizures	3,013	0.5	859	28
ADHD/ADD	17,544	3.0	105	.06
Neuropsychological Disorders	4,548	0.8	188	4
Others	2,475	0.4	297	12
Total	67,441	12.0	9,428	14

Issues/Concerns

- The system of care for children with special health care needs is complex, making it difficult for families to identify payment sources, locate family support, and access needed services. Families need and desire a primary point of contact for care coordination who helps them navigate the health, social service, and educational systems and can most adequately meet the needs of the child and family.
- Care coordination in Washington State is fragmented.
- In many cases, a child's care coordinator coordinates only portions of the scope of services that the child uses.
- In many cases, a child may have multiple care coordinators from multiple agencies who may not communicate with each other.
- The term care coordinator has different meanings among agencies.
- Many of the policy and procedure barriers can be addressed through increased communication and collaboration across local agencies.

[5] Washington State Office of Superintendent Public Instruction, 2004.

Early Hearing Loss Detection, Diagnosis, and Intervention Program (EHDDI)

What is the service?

- All infants born in Washington are screened for the *"**1-3-6 National goals**":*
  - Hearing loss screening before discharge or up to **1** month of age
  - If positive, diagnostic evaluation from pediatric audiologist by **3** months of age
  - If hearing loss found, enrollment in early intervention programs by **6** months of age
- Tracking and surveillance system in Washington State is performed to assess if the 1-3-6 goals are being met and to evaluate the program.
- For a more detailed overview of the program, go to the website: www.doh.wa.gov/ehddi
  - Report to Washington State Board of Health members: Universal Newborn Hearing Screening in Washington State, April 2005

How/where is the service provided?

- Most hearing screening occurs prior to newborn hospital discharge. Currently, 68 of 69 birthing hospitals have universal newborn hearing screening programs.
- EHDDI supports Universal Newborn Hearing Screening by:
  1) Monitoring if every infant receives a newborn hearing screening result through screening results submitted to the state by birthing hospitals.
  2) Assisting in follow-up care by contacting the child's Primary Care Provider if they have an abnormal hearing screen result.
  3) Providing Quality Assessment and Control through program evaluation and ongoing reports to birthing facilities doing this screening

Eligibility

- No eligibility requirements
- Goal is screening of 100% of all infants born in Washington State

Who is receiving service?

Washington State Universal Newborn Hearing Screening Rates, 2005 [1]

Year	Percent of Infants Screened
1998	3.9
1999	7.6
2000	23.5
2001	42.4
2002	62.2
2003	81.3

2004	85.0
2005 (Estimated)	95.0

Issues/concerns[1]

- Unexpected program implementation delays may have caused lower screening rate than expected for 2004
- Concerns about infants lost to follow-up
- Additional evaluation needed to identify and support follow-up care for at-risk infants.
- Inadequate early intervention opportunities for those infants identified with hearing loss.
- Policy and regulatory challenges with voluntary versus required newborn hearing screening
- Sustainability for Universal Newborn Hearing Screening

Early Learning and Child Care
- Child Care Services -

- A variety of publicly funded programs and services addressing child care are offered across Washington State. It is estimated that over 250,000 Washington children are in some type of child care. The Washington State Department of Social and Health Services Division of Child Care and Early Learning is responsible for regulating licensed child care facilities and managing child care subsidies. The Washington State Department of Health and other agencies provide infrastructural support to assist providers in providing quality child care services.

DSHS Division of Child Care and Early Learning Services

What is the service?

- Division of Child Care and Early Learning (DCCEL), part of the Department of Social and Health Services (DSHS), seeks to provide coordinated and comprehensive child care for families and child care providers.[1]
- DCCEL website: http://www1.dshs.wa.gov/esa/dccel/index.shtml
- DCCEL licenses child care homes and centers, and works to ensure that licensing requirements are met.[2]
    - Licenses must be renewed every 3 years
    - Child care homes are monitored every 18 months
    - Child centers are monitored every year
- DCCEL manages Working Connections Child Care (WCCC), which provides subsidized child care services to families in the Workfirst program and working families at or below 200% of the federal poverty level.
- DCCEL collaborates with the federal Head Start program
    - For more information please see the separate Services Chapter entitled *"Early Learning and Child Care: Head Start, Early Head Start, and ECEAP"*
- DCCEL handles complaints and questions, and provides resources through referrals and mailings.
- DCCEL develops policies and procedures regarding licensing requirements, rules, etc.
- DCCEL manages statewide contracted programs which:
    1. Pay subsidies for child care for homeless families and seasonally employed agricultural workers.
    2. Provide parents information on local licensed child care and how to select child care.
    3. Assist providers with locating resources and provide professional development.
- DCCEL presents research and data analysis.

[1] Washington State Department of Social and Health Services, Economic Services Administration. "Division of Child Care and Early Learning". Website: http://www1.dshs.wa.gov/esa/dccel/glossary.shtml#wccc. Accessed October 2005.

[2] According to the Washington State Department of Social and Health Services, "A **Child Care Home** is a facility in the family residence of the licensed provider that provides regularly scheduled care for twelve or fewer children, aged zero through eleven-years old. A **Child Care Center** is a facility providing regularly scheduled care for a group of children one month of age through twelve years of age for periods less than twenty-four hours."

How/where is it provided?

- Child care is provided by approximately 9,000 licensed centers and homes across Washington as well as family, friends, and neighbors.

Who is eligible?

- DCCEL works with all child care providers.
- All children in Washington can attend licensed child care.
- Families in the Workfirst program and working families with incomes at or below 200% federal poverty level are eligible to receive subsidized child care.

Who is receiving the service?

- Approximately 166,000 children were enrolled in licensed child care centers and homes in 2004.
- It is estimated that another 90,000 children are in unlicensed care.
- Almost 30% of licensed care is subsidized by the Washington State Department of Social and Health Services (DSHS).
- While not all sites are currently serving DSHS clients, most sites are willing to serve these children.

Estimates of Children in Licensed and Unlicensed Child Care, 2004 [3,4]

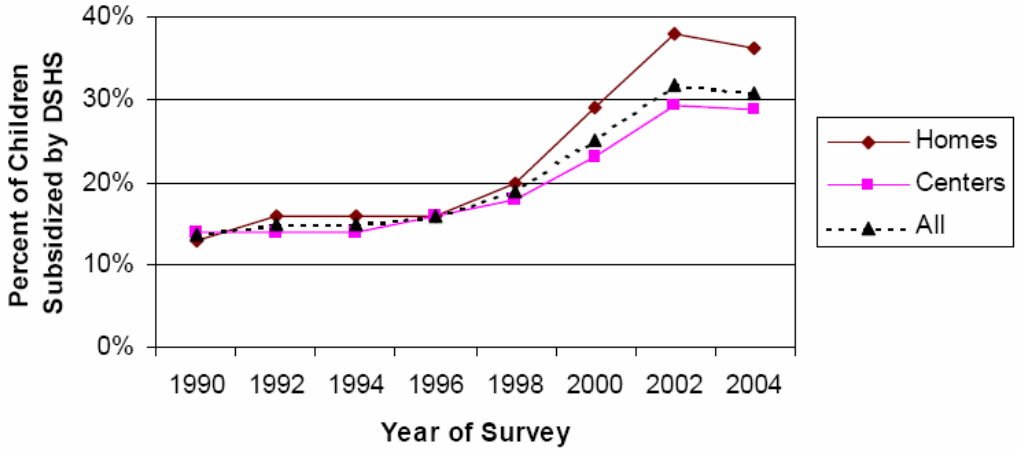
	Children Enrolled
Licensed Care	
Childcare Centers	118,700
Family Homes	46,980
Total Licensed Care	165,680
Unlicensed Care	
Out-of-Home	54,470
In-Home	36,230
Total Unlicensed Care	90,700
Total in Child care	256,380

[3] Unlicensed care was estimated from proportions in 1990 Child Care Survey. [*Child Care Rates in Washington: 1990*]
[4] Licensed Child Care in Washington State, 2004. Division of Child Care and Early Learning, Economic Services Administration, Washington State Department of Social and Health Services, 2005, page 9.

Availability and Use of Licensed Child Care [5]

	Number of sites	Percent of Sites Currently Serving DSHS Children	Percent of Sites Willing to Take DSHS children	Total Child Care Slots	DSHS Subsidized Slots	Percent of Total Slots which are Subsidized	Vacant Slots	Percent of Total Slots which are Vacant
Licensed Centers	2,134	87%	96%	124,683	34,091	27%	20,241	16%
Licensed Homes	6,875	66%	94%	58,728	17,035	29%	11,544	20%
Total Licensed Facilities	9,009	71%	94%	183,411	51,126	28%	31,966	17%

DSHS Subsidized Children as Percent of All Children in Licensed Facilities, 1990-2004 [2]



Source: DSHS Division of Child Care and Early Learning
1990, 1992, 1994, 1996, 1998, 2000, 2002 and 2004 Surveys of Child Care Centers and Family Homes

[5] Licensed Child Care in Washington State, 2004. Division of Child Care and Early Learning, Economic Services Administration, Washington State Department of Social and Health Services, 2005, page 63 and Tables A1, A2, A4 on pages 84-87.

Department of Health - Healthy Child Care Washington (HCCW) Services

What is the service?

- HCCW is an Initiative administered by the Washington State Department of Health committed to building a system to improve the quality of child care through promoting and integrating health and safety in child care and early childhood
- Website: http://www.healthychildcare-wa.org/index.htm

***Systems Level Activities*:**
HCCW works with several programs within the Washington State Department of Health as well as externally to establish, enhance, and increase partnerships with child care and early childhood stakeholders.

- HCCW disseminates *Bright Futures* materials with national guidelines for children's healthy growth and development to child care providers
- HCCW contracts with *Pacific Rim Real-Time Systems, Inc.* to provide consultation, technical assistance, and training to Child Care Health Consultants (CCHCs) at Local Health Jurisdictions.
- HCCW provides intensive training emphasizing the social-emotional needs of children and how CCHCs can assist child care providers to attend to the deeper needs underlying outward socio-behavioral manifestations through the Promoting First Relationships (PFR) Program. Website: http://www.son.washington.edu/centers/pfr/
- HCCW partners with *Washington State Child Care Resource & Referral Network* to help align health and safety in child care and link local Child Care Resource and Referral agencies with their Local Health Jurisdictions. See Washington State Resource and Referral Network below.
- HCCW is involved in an outcome-based evaluation to identify the changes that occur in the lives of families and communities as a result of Child Care Health Consultation. Website: www.organizationalresearch.com

Child Care Health Consultation

- Child Care Health Consultants (CCHCs), located in every Local Health Jurisdiction (LHJ) in Washington State, provide consultation, technical assistance, and training regarding health, safety, and development of infants and toddlers to licensed child care centers and homes in their local communities. Most CCHCs are Public Health Nurses.
- CCHCs work with child care providers to promote actual changes in knowledge, behavior, policy, environment, and communication with parents.

Who is eligible?

- Child care health consultation is available to all licensed or exempt child care providers caring for infants and toddlers. Some counties have additional funding sources and services are available to providers caring for older children. While services are also available to informal child care providers (family, friends and neighbors), an emphasis is placed on licensed providers.

Washington State Child Care Resource & Referral Network Services

What is the service?

- This network of eighteen local programs receives funding in part from DCCEL. The program is designed to disseminate information on licensing and child care providers to parents, train professionals, provide caregiver support, and assist businesses in offering programs that benefit employees.[6]
- Website: http://www.childcarenet.org/

How/where is it provided?

- There are 18 local programs serving Washington families across the state.

Who is eligible?

- All Washington families are eligible.

Who is receiving the service?

- During 2004 the Network's member agencies: [7]
    - Helped 13,239 low-income families find child care
    - Assisted 23,687 families and 34,472 children
    - Fielded 105,554 calls
- The annual median Washington State household income for 2004 was $51,762. The following table illustrates the average costs of child care centers and family child care (FCC).[4]

Average Costs of Child Care Centers and Family Child Care

	Centers		Family Child Care	
Age of Child	2004 Median Annual Cost	% of Median Household Income	2004 Median Annual Cost	% of Median Household Income
Infant	$8,476	16%	$6,500	13%
Toddler	$7,280	14%	$6,500	13%
Preschool	$6,648	13%	$5,720	11%
School Age	$3,796	7%	$2,860	6%

[6] Washington State Resource and Referral Network, "History, Mission, and Vision." Website: http://www.childcarenet.org/history.htm. Accessed October 2005.
[7] Washington State Resource and Referral Network, "2005 State Data Report". Website: http://www.childcarenet.org/05%20State%20Report.pdf. Accessed October 2005

Schools Out Washington Services

What is the service?

- *Schools Out Washington (SOWA)* is an organization focused on improving after-school programs for children ages 5-14 years around Washington State
- This community-based organization focuses on enhancing the availability, affordability, and quality of after-school programs for all children; with a special emphasis on those with low socioeconomic status and children with special needs
- Website: http://www.schoolsoutwashington.org/

How/where is it provided?

- SOWA provides a variety of services to improve after-school programs, including professional development, advocacy, funding opportunities, and educational tools.

Issues/concerns [3]

- Three of the top challenges to finding child care are:
  - Affordability
    - The cost of child care has increased much faster than inflation over the past 14 years, and currently is estimated to be between 6-26% of the median household income in Washington.
  - Quality of care
    - With increased understanding of the importance of early learning and socioemotional development, the quality of child care is paramount. It is challenging to ensure quality care given the low wages and turnover in child care providers.
  - Availability of openings
    - Approximately 17% of total licensed child care slots are vacant across the state, but this proportion varies by age of the child and location.

Early Learning and Childcare
– Head Start, Early Head Start, & Early Childhood Education Assistance Program --

What is the service?

- Comprehensive early childhood education and family assistance services to promote school readiness. Programs include comprehensive health screening covering physical, developmental, dental, nutritional, mental health and immunization needs; promotion of school readiness through socio-behavioral development; family support; and transportation. Families are also referred to appropriate community agencies to address health needs.
- Services at Head Start (HS), Early Head Start (EHS) and Early Childhood Education Assistance Program (ECEAP) are very similar regarding school readiness promotion; noticeable differences are seen in funding, client demographics, and intensity of services. Migrant and Seasonal Head Start Programs provide similar comprehensive services to migrant and seasonal farm-worker families.[1]
- Parental involvement is highly encouraged. Volunteer opportunities available at program sites, performing outreach activities, and taking part in the Washington State Association of Head Start and ECEAP (an advocacy organization comprised of 50% parents, 25% staff, and 25% directors).
- Website: http://www1.dshs.wa.gov/pdf/esa/dccel/hsstateprofile2001-2002.pdf

Description and Comparison of HS/EHS/ECEAP

<table>
<tr><th></th><th>HS/EHS [2]</th><th>ECEAP [3]</th></tr>
<tr><td>Funding</td><td>▪ Federal funded (directly to local, bypassing state)
▪ Regulated and monitored by federal government</td><td>▪ Mostly state funded
▪ Regulated and monitored by state</td></tr>
<tr><td>Eligibility</td><td>*Targets low-income, at-risk, and those with disabilities
*100% and under FPL

Actual Enrollment by Type of Eligibility, 2004
Receipt of public assistance 4,277 23.0%
Income eligible (< 100% FPL) 12,785 68.7%
Over income (>100% FPL) 1,130 6.1%
Foster children 424 2.3%</td><td>▪ Targets low-income, at-risk, and those with disabilities
▪ 110% and under FPL

Household FPL Status, 2005
80% of FPL and Under 4203 61.60%
81%-100% FPL 1398 20.50%
101%-110% FPL 749 11.00%
111%-130% FPL 195 2.90%
131%-200% FPL 217 3.20%
> 200% FPL 66 1.00%</td></tr>
</table>

[1] Head Start, Early Head Start, & ECEAP State Profile 2001-2002. Website: http://www1.dshs.wa.gov/pdf/esa/dccel/hsstateprofile2001-2002.pdf Accessed 4/05.
[2] Head Start and Early Head Start State Profile Data and Charts, 2004. Accessed 8/05
[3] Early Childhood Education and Assistance Program, Data and Charts as of 6/30/05. Accessed 8/05

	HS/EHS [4]	ECEAP [5]
Demographics	**Actual Enrollment by Ethnicity, 2004** *(Including AIAN and Migrant/Seasonal)* American Indian/ Alaska Native (AIAN) 1,236 6.6% Asian 813 4.4% Black/African-American 1,480 8.0% Hispanic/Latino 7,120 38.3% Native Hawaiian/ Pacific Islander 148 0.8% White 5,893 31.7% Bi-racial/Multi-racial 1,571 8.4% Other 11 0.1% Unspecified 344 1.9% **Actual Enrollment by Child Age, 2004** Under one year 1,205 6.6% One year old 1,235 6.7% Two years old 1,404 7.6% Three years old 4,707 25.6% Four years old 9,044 49.2% Five years and older 773 4.2% **Actual Enrollment of Children by Health Insurance, 2004** Medicaid/EPSDT 13,735 74.8% State CHIP 306 1.7% Combined State CHIP/Medicaid 526 2.9% State-only funded 713 3.9% Private 954 5.2% Other 640 3.5% Uninsured 1,494 8.1% **Actual Enrollment of Pregnant Women by Health Insurance, 2004** Insured 217 87.5% Uninsured 31 12.5%	**Children's Race, 2005** *(Totals can be >100% because may count more than one race)* White 3609 52.90% American Indian/ Alaska Native 363 5.30% Asian 344 5.00% Black/African American 842 12.30% Native Hawaiian/ Pacific Islander 162 2.40% Some Other Race 859 12.60% No Response 1273 18.60% **Children's Ethnicity, 2005** Hispanic 2592 38.0% Non-Hispanic 3987 58.4% Ethnicity not reported 255 3.6% **Cumulative Enrollment: 6828** **Cumulative Enrollment by Gender, 2005** Male 3429 50.20% Female 3399 49.80% **Cumulative Enrollment by Child's Age, 2005** 3 Year Olds 1457 21.20% 4 Year Olds 5377 78.70% 5 Year Olds 4 0.10% Over 5 Year Olds 0 0.00% **Children's Medical/Dental Coverage, 2005** Healthy Kids 1538 22.50% WA Basic Health Plan 626 9.20% Private Medical Insurance 445 6.50% Medicaid 2894 42.40% CHIP 160 2.30%

[4] Head Start and Early Head Start State Profile Data and Charts, 2004. Accessed 8/05

[5] Early Childhood Education and Assistance Program, Data and Charts as of 6/30/05. Accessed 8/05

		Private Dental Insurance 319 4.70% Other 861 12.60% None 606 8.90%
Intensity of Services	▪ Usually longer in duration and service intensity than ECEAP	
Served	▪ Children up to age 5 years and their families **Number of Centers by Program** *(Excluding family care centers)* Head Start 257 72.4% Early Head Start 42 11.8% AI/AN Head Start 24 6.8% AI/AN Early Head Start 2 0.6% Migrant/Seasonal Head Start 30 8.5%	▪ Children ages 3-4 years and their families (priority given to 4 year-olds)

Issues/Concerns

- *Administrative changes:*[6]
  - Reauthorization bill passed the House in May 2005 and is pending in the Senate.
  - Bills focus on increasing Head Start coordination with other services for early childhood learning, improving staff qualifications, fiscal accountability and increasing competition among Head Start grantees.
  - Concerns that the National Reporting System (NRS), which require all 4 year old Head Start children to be tested, will be the only data used to evaluate agencies and assess funding.[7]
- *Unfunded Mandates/Accountability without new resources:*
  - U.S. Senate Bill #1107, if passed, would raise teacher qualification requirements without providing additional funding, resulting in possible $3.4 billion funding gap. Potential side effects include: teacher layoffs, reduced operation hours, reduced transportation provisions.[8, 9]
  - US Reauthorization bill in Senate would limit role of parents, especially fathers, in Head Start program involvement.[10]
- *ECEAP-specific:*
  - Contractors would like to see increased funding per child to align more with Head Start funding.

[6] CRS Report for Congress, "Head Start: Background and Issues". Website: http://www.ccsso.org/content/pdfs/CRSHeadStartReport.pdf Accessed 3/8/2006.

[7] Nation's Network of Child Care Resource and Referral Agency, "Policy Update: Head Start Reauthorization Moves Forward in Congress". Website: http://www.naccrra.net/policy/?id=51. Released 6/6/05.

[8] National Head Start Association, "$3.4 Billion Head Start "Funding Gap" seen as Congress moves to raise teacher degree requirements without paying more for the improvement in quality". Website: http://www.saveheadstart.org/071405release.html. Released 7/14/05

[9] Hart K., Schumacher R. *Center for Law and Social Policy (CLASP*), "Making the Case: Improving Teacher Qualifications Requires Increased Investment". Website: http://www.clasp.org/publications/hs_policy_paper_1.pdf. Released 7/05.

[10] National Head Start Association (NHSA). "Pending US Senate Head Start Bill would undercut role of nearly 200,000 fathers across United States" Website: http://www.saveheadstart.org/061605_NHSA_FathersDay_Release.html. Released 6/16/05

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

What is the service?

- The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is a federal preventive health care benefit. The purpose of this program is to screen clients 20 years of age and younger in order to identify physical and/or mental health problems. If a physical or mental health problem is identified, the client should be treated or referred to an appropriate provider for treatment. EPSDT is designed to encourage continuing access to health care.
- Dual objectives:[3]
  - Ensure accessibility and availability of resources
  - Facilitate the use of these resources by recipients and their families
- Services available include:[1, 3]
  - Comprehensive health and developmental history, including a developmental assessment of physical and mental health
  - Comprehensive physical examination
  - Immunizations, based on the current approved Advisory Committee on Immunization Practices schedule
  - Laboratory tests, including mandatory lead screening
  - Vision, hearing, and dental screening
  - Health education and anticipatory guidance
- Websites:
  - http://fortress.wa.gov/dshs/maa/CHIP/ClientGuide/HealthyKidsEPSDT.html
  - http://www.cms.hhs.gov/medicaid/epsdt/default.asp

How/where is the service provided?

- Provided by physicians, specially trained nurses, nurse practitioners, and physician assistants
- If recipients receive positive screen, can either be treated or referred appropriately
- Required screening periods:[3]
  - Ages 1-2 years = three screenings
  - Ages 2-6 years = one screening per year
  - Ages 7-20 years = one screening every 2 years (except foster care = one per year, and within one month of placement)
- Recommended screening periods:[3]
  - 1st = Birth to 6 weeks
  - 2nd = 2-3 months old
  - 3rd = 4-5 months old
  - 4th = 6-7 months old
  - 5th = 9-11 months old

[1] Maternal and Child Health Bureau, Maternal and Child Library, "Knowledge Path: Early and Periodic Screening, Diagnosis, and Treatment Services". Website: http://www.mchlibrary.info/KnowledgePaths/kp_EPSDT.html. Accessed 5/15/05

Eligibility

- Below 21 years old
- No cost to client if eligible for Medical Assistance[2, 3]

Who is receiving the service?

Washington State EPSDT Participation, FY 2004[4]

Age Groups	Total Individuals Eligible for EPSDT[5]	Total Eligibles Who Should Receive at least one Initial or Periodic Screen[6]	Total Eligibles Receiving at least one Initial or Periodic Screen[7]	Percent Receiving At Least one Initial or Periodic Screen[8]
<1	37,187	37,201	30,711	82.6%
1-2	83,626	69,449	56,565	81.4%
3-5	115,484	97,054	47,967	49.4%
6-9	134,968	85,083	27,716	32.6%
10-14	153,813	52,341	34,675	66.4%
15-18	104,644	42,950	16,840	39.2%
19-20	31,164	10,294	1,566	15.2%
Total	661,357	394,372	216,040	54.8%

The data presented above reflects all individuals < 21 enrolled in Medicaid regardless of whether they receive fee-for-service or managed care services. Seventy percent of Medicaid children are enrolled in managed care in the state of Washington. Through its managed care organization (MCO) contracts, the Department of Social and Health Services Medicaid program requires health plans to report performance measures on a yearly basis. One of the available measurement tools in the health care industry is the Health Plan Employer Data and Information Set (HEDIS). HEDIS is used by more than ninety percent of health plans in the U.S. to measure quality.

Among the HEDIS performance measures reported to Medicaid each year are well-child care measures. EPSDT screenings are often provided in the context of well child care visits. The HEDIS well child care measures look at the adequacy of well-child care for infants, birth to 15 months of age, children 3 to 6 years of age, and adolescents 12 to 18 years of age. Samples of

[2] Washington State Department of Health, "Side-by-side comparison of EPSDT, USPSTF, and AAP". Website: http://www.doh.wa.gov/SBOH/Meetings/Meetings_2000/2000-10_11/documents/Tab05-EPSDTSide-by-side.doc Accessed 5/15/05
[3] Washington State Department of Social and Health Services, Medical Assistance Administration, "Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program". Website: http://fortress.wa.gov/dshs/maa/download/billinginstructions/epsdt_bis_11-12-04.pdf. Posted 11/04
[4] Washington State Department of Social and Health Services, Medical Assistance Administration, 2004 data from CMS-416 form. 2004 Washington data are not yet posted, however 2003 Washington data are posted at www.cms.hhs.gov/medicaid/epsdt/ep2003.pdf.
[5] Unduplicated number of individuals < 21 years determined to be eligible for EPSDT services.
[6] Unduplicated number of individuals <21 who should receive at least one EPSDT service based on the average period of eligibility of clients and scheduled periodicity of services.
[7] Unduplicated number of individuals who received at least one documented EPSDT service
[8] Percent of the total eligibles who should receive a screen who actually received at least one documented initial or periodic screen.

children from each age category are selected and the rate of children receiving well-child care is calculated for each age category. Children are randomly selected for inclusion in the rate calculation based on continuous enrollment criteria with one health plan. Children and adolescents must be enrolled in one health plan for 12 continuous months (with allowance of a one month gap in enrollment) to be included; infants must be enrolled from 31 days of age (allowing a one month gap in enrollment) to 15 months of life. The statewide average among all MCOs reported in 2004 is presented below.[9]

- Medicaid Well Child Visits in First 15 months (receiving at least one visit): 98.6%
- Medicaid Well Child Visits in First 15 months (receiving at least six visits): 40.0%
- Medicaid Well Child Visits of 3-6 year olds (receiving at least one visit per year): 51.0%
- Medicaid Adolescent Well Care Visits of 12-18 year olds (receiving at least one visit per year): 33.3%

Issues/concerns

- Both increasing the number of children who receive preventive health exams, and improving the quality of the preventive care they receive have been persistent issues, despite several comprehensive quality improvement initiatives.
- Low numbers of specialty Medicaid providers may limit access to specialty care referrals for conditions discovered during screening exams.
- Reimbursement terminology for preventive exams may be confusing to parents, providers, and payers
- Providers may lack the communication skills necessary to explain health information to parents, particularly those with lower medical literacy.
- The current structure and content of EPSDT exams may no longer be the best way to ensure the highest quality preventive care to children. HRSA and DOH are in the process of considering initiatives that would increase the value and relevance of the EPSDT exam to clinicians, parents, and children.

[9] Washington State Dept of Social and Health Services Medical Assistance Administration, "Washington State 2004 HEDIS Report", 2005. Available at http://fortress.wa.gov/dshs/maa/newsdoc/2004HEDISReport1605.pdf

Emergency/Temporary Housing Services

What is the service?

- Emergency shelters and transitional housing programs for homeless families and individuals in Washington are supported by public funding from the State Department of Community Trade and Economic Development (CTED) together with non-profit, private, local, and federal funds.
- In addition to providing shelter, services are provided to help homeless individuals obtain permanent housing and to prevent homelessness for those at immediate risk of becoming homeless.
- Housing programs include the Emergency Shelter Assistance Program; Transitional Housing, Operating and Rent; Tenant Based Rental Assistance; Farmworker Housing; and Overnight Youth Shelters.
- Additional social services for homeless individuals and families are provided by the Washington State Department of Social and Health Services. See sections on Financial Assistance to Needy Families, Nutrition Services, and Childcare Services. Child Protective Services also provides services but is not currently included in this report pending the reorganization of services.
- Website: http://www.cted.wa.gov/portal/alias_CTED/lang_en/tabID_474/DesktopDefault.aspx

Emergency Shelter Assistance Program

Description: The Emergency Shelter Assistance Program (ESAP) provides funding to support emergency shelters throughout Washington. State funding is matched by community resources and supplemented by federal emergency shelter funding.

People receiving services supported by ESAP can receive up to 90 days assistance in the form of
- traditional shelter
- rent/mortgage assistance to avoid eviction
- first month's rent deposit
- landlord mediation
- case management services

How/where are services provided?: ESAP helps support a network of 172 community-based emergency shelters throughout Washington. A list of organizations providing housing and related services is available at www.endhomelessnesswa.org

Who is receiving the service? In SFY 2004, 44,988 individuals in 31,362 households received 1,352,357 bednights of shelter; and 48,915 individuals in 30,030 households received 655,900 bednights of prevention. See details in the following tables.

Individuals Served by Emergency Shelter Assistance Program Washington State, SFY 2004[1]				
	Individuals Provided Shelter		Individuals Provided Prevention Services	
Age	**Number**	**Percent**	**Number**	**Percent**
0-5 years	5,253	11.7%	5,992	12.2%
6-11 years	3,662	8.1%	4,897	10.0%
12-17 years	3,564	7.9%	4,129	8.4%
18-21 years	2,918	6.5%	2,350	4.8%
22-44 years	19,134	42.5%	18,549	37.9%
> 44 years	10,457	23.2%	12,998	26.6%
Total	44,988	100%	48,915	100%
Race/ethnicity				
White	24,718	54.9%	31,701	64.8%
Hispanic	4,941	11.0%	5,627	11.5%
African American	9,535	21.2%	6,135	12.5%
Native American	2,534	5.6%	2,186	4.5%
Asian	752	1.7%	560	1.1%
Other	2,508	5.6%	2,706	5.5%
Total	44,988	100%	48,915	100%

Traditional Housing, Operating, and Rent

Description: The Traditional Housing, Operating, and Rent (THOR) program provides homeless families with up to two years rental assistance, subsidies to support transitional facilities housing homeless families, and case management to help families transition to permanent housing and self-sufficiency. Participants collaborate with case managers to set goals to address barriers to self-sufficiency, and case managers connect families to a wide variety of services.

How/where are services provided?: Program services are delivered through housing authorities, community action agencies and local governments that collaborate with other local service providers.

Eligibility: Homeless families with children under 18 years or pregnant women with incomes at or below 50% of the median household income for their county are eligible if they agree to create a Housing Stability Plan and participate in achieving it.

Who is receiving the service?: In SFY 2004, 1,356 new families were served.

[1] 2005 Emergency Shelter Assistance Program Report. Washington State Department of Community, Trade and Economic Development accessed at http://housing-information.net/report/index.php on 11/10/05.

Tenant Based Rental Assistance

Description: The Tenant Based Rental Assistance (TBRA) program provides homeless and low-income households with security and utility deposits and up to 12 months of rent assistance. Households receive a combination of deposits and subsidies that enable them to pay no more than 30 percent of their income for rent and utilities.

How/where are services provided?: Program services are delivered through housing authorities, community action agencies, and local governments that collaborate with other local service providers.

Eligibility: Eligible households have incomes that do not exceed 50% of the median household income for their area.

Who is receiving the service?: In SFY 2004, 4,169 new families were served.

Farmworker Housing

Description:. The Farmworker Housing Program provides grants and loans to non-profit organizations and local governments to develop both permanent and seasonal housing for farmworkers and migrant workers. They assist growers by helping to finance the infrastructure needed to develop and manage housing on their farms. They also provide emergency housing vouchers for migrant workers displaced due to health and safety reasons.

How/where are services provided?: Program services are delivered through housing authorities, community action agencies and local governments that collaborate with other local service providers.

Eligibility: (see above)

Who is receiving the service?: As of 2002, 725 units of permanent housing and 4,054 seasonal beds had been developed since 1999. In addition, 3,059 bednights of emergency shelter have been provided to migrant workers living in unsafe conditions.

Overnight Youth Shelters

Description: The Licensed Overnight Youth Shelter program provides funding to assist youth shelters in King, Skagit, Snohomish, and Spokane counties to meet the Department of Social and Health Services licensing requirements to serve youth ages 13-17. Youth served by these shelters have run away or are homeless due to family problems. Additional services for runaway and homeless youth are provided by the Children's Administration of the Department of Social and Health Services. See http://www1.dshs.wa.gov/ca/services/srvAdlsFAQ.asp

How/where are services provided?

The four youth shelters include:

VOA – Crosswalk
Spokane, WA
http://www.voaspokane.org

Cocoon House
Everett WA
http://cocoonhouse.org

TeenHope
Shoreline, WA
http://www.teen-hope.org/

Skagit Valley Family YMCA
Mount Vernon, WA
Email: oasisteenshelter@hotmail.com

Eligibility: Any homeless youth.

Who is receiving the service?: In 2004-2005, the Overnight Youth Shelter Grant assisted in providing 5,505 bednights of shelter to 384 youth, with 525 youth turned away for a variety of reasons.

Issues/Concerns

- The high cost of housing combined with low incomes continues to push many Washington families into homelessness. In SFY 2004, 173,056 individuals in 83,379 households were turned away from shelters and 116,808 individuals in 50,621 households were turned away from prevention services. 51% of the households turned away from shelter were households with children.
- The need for farmworker housing continues to exceed the services available.
- The need for shelter and services for homeless youth is particularly acute.

Family Planning

What is the service?

- Publicly funded family planning services in Washington include federal Title X services, and state funded programs administered by the Department of Health (DOH), as well as TAKE CHARGE and Pregnancy Extension services administered by the Department of Social and Health Services (DSHS).
- DOH's Family Planning and Reproductive Health section provides federal funds to clinics through Title X of the Public Health Services Act (U.S. Department of Health and Human Services) and state general funds. In addition to contraceptive services, clinics provide patient education and counseling; breast and pelvic examinations; cervical cancer screening; STD and HIV screenings; and pregnancy diagnosis and counseling. Men and women, both citizens and non-citizens, are eligible.
- TAKE CHARGE, a Medicaid research and demonstration project, was implemented by the Washington DSHS in July of 2001. TAKE CHARGE provides pre-pregnancy family planning services to low-income men and women at no cost to the client. The goal of the program is to reduce unintended pregnancy, lengthen the interval between births, and to reduce Medicaid expenditures for unintended births.
- Women who are Medicaid-eligible solely because of pregnancy continue to have Medicaid coverage for medical services (including post-pregnancy contraceptive services) for two months after the end of their pregnancy. After two months, those women who were Medicaid-eligible solely because of pregnancy receive a ten-month extension of eligibility for family planning services only (called Pregnancy Extension below). At the end of the ten month extension, women who are U.S. citizens may be enrolled in the TAKE CHARGE program, if they apply. Non-citizens are not eligible for TAKE CHARGE.
- Women whose Medicaid eligibility is unrelated to pregnancy continue to be eligible for full-scope Medicaid coverage, including family planning services, as long as they are Medicaid eligible.
- Individuals, including non-citizen immigrants, can receive contraceptive services through Community Health Centers. Fees are based on a sliding scale for those with incomes at or below 200% FPL. See *Safety Net Services* chapter for more information about Community Health Centers.

How/where is the service provided?

- In Washington State, Title X provides funding to 19 family planning agencies (10 of which are local health departments), which provide services at 65 sites. Washington state funds go to Title X agencies plus an additional 3 agencies for a total of 22 agencies and 77 sites.
- As of June 30th, 2004, 84 TAKE CHARGE providers offered services at 176 clinic sites.
- The majority of TAKE CHARGE clients are served by 10 family planning agencies (all of which are also Title X agencies). TAKE CHARGE providers also include 15 local health departments, 14 community clinics, and two university student health centers.

Eligibility

- Title X and DOH state funded family planning services are charged on a sliding fee scale for clients with incomes between 100% and 250% FPL. Clients whose income is at or below 100% FPL receive services at no charge to the client.
- Men and women who are not otherwise Medicaid-eligible, with family incomes at or below 200% of the FPL, are eligible for TAKE CHARGE if they are seeking to prevent unintended pregnancy. If a TAKE CHARGE client has partial coverage through another health insurance plan, then that plan will be billed first.
- Pregnant women with family incomes at or below 185% of the FPL are eligible for Medicaid-paid maternity care and for the ten month Pregnancy Extension (Family Planning Only).

Who is receiving the Service?

Clients receiving family planning services in Washington at clinics receiving at least some public funding, 2004 (Services include Title X, DOH state funded family planning, TAKE CHARGE, and Pregnancy Extension services.)
(Note: Columns are not mutually exclusive. Numbers should not be totaled across columns)

	Title X[1]		DOH State Funded[2]		TAKE CHARGE[3]		Pregnancy Extension[4]	
	Number	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Sex								
Female	130,865	94%	49,409	90%	100,272	95%	26,455	100%
Male	7,961	6%	5,770	10%	5,255	5%	not eligible	
Total	138,826	100%	55,179	100%	105,527	100%	26,455	100%
Age								
< 17	18,084	13%	7,090	13%	15,312	15%	667	3%
18-19	22,424	16%	9,364	17%	20,493	19%	2,189	8%
20-24	48,481	35%	20,718	38%	41,220	39%	10,591	40%
25-34	42,798	31%	13,901	25%	22,117	21%	11,040	42%
35+	7,039	5%	4,106	7%	6,385	6%	1,958	7%

[1] Unduplicated clients served in 2004 at clinics receiving some funding from Title X, as reported in Title X Client Visit Record Database, Infectious Disease and Reproductive Health Assessment, Washington State Department of Health, 8/05.
[2] Unduplicated clients served in 2004 at clinics receiving some Washington State General Funds from Department of Health Family Planning and Reproductive Health Program, Infectious Disease and Reproductive Health Assessment, Washington State Department of Health, 8/05. Data do not include about 350 clients seen at the Seattle Indian Health Board in 2004.
[3] Unduplicated TAKE CHARGE clients who received any service in 2004, Medical Assistance Administration, Department of Social and Health Services, 8/05.
[4] Unduplicated Pregnancy Extension clients who received any service in 2004, Medical Assistance Administration and First Steps Database, Department of Social and Health Services, 8/05.

	Title X[5]		DOH State Funded[6]		TAKE CHARGE[7]		Pregnancy Extension[8]	
	Number	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Race					Not Available		Not Available	
White	101,876	73%	41,757	76%				
Black	6,043	4%	3,354	6%				
AIAN[9]	2,045	2%	752	1%				
Asian	6,911	5%	3,212	6%				
NHOPI[10]	1,729	1%	806	1%				
Other	15,497	11%	2,269	4%				
Multiple	4,725	3%	3,029	5%				
Ethnicity								
Hispanic	20,355	15%	3,465	6%				
Non-Hispanic	118,471	85%	51,714	94%				

Issues/Concerns

- Although Title X does not pay for abortion services, Congress has increasingly linked Title X to abortions. In FY 2005, Congress passed an appropriations rider that could negate the ability of a Title X clinic to supply an abortion referral to a woman facing an unintended pregnancy. In addition, abortion opponents in Congress report that their top priorities include a ban on Title X funding to clinics that use private funds to provide abortions. [11]
- Nationally, after adjusting for inflation, Title X funding has remained essentially constant since 1980[12] even though the population needing services has increased. Title X clinics are confronting the increased cost of contraceptives and the increasing numbers of uninsured individuals.[13]
- At both the state and national levels, Medicaid expenditures continue to grow despite current cost containment efforts. Continuing budget shortfalls and reductions in services consistent with available resources are predictable.

[5] Unduplicated clients served in 2004 at clinics receiving some funding from Title X, as reported in Title X Client Visit Record Database, Infectious Disease and Reproductive Health Assessment, Washington State Department of Health, 8/05.
[6] Unduplicated clients served in 2004 at clinics receiving some Washington State General Funds from Department of Health Family Planning and Reproductive Health Program, Infectious Disease and Reproductive Health Assessment, Washington State Department of Health, 8/05. Data do not include about 350 clients seen at the Seattle Indian Health Board in 2004.
[7] Unduplicated TAKE CHARGE clients who received any service in 2004, Medical Assistance Administration, Department of Social and Health Services, 8/05.
[8] Unduplicated Pregnancy Extension clients who received any service in 2004, Medical Assistance Administration and First Steps Database, Department of Social and Health Services, 8/05.
[9] American Indian/Alaska Native
[10] Native Hawaiian/Other Pacific Islander
[11] Gap Widening Between U.S. Women's Birth Control Needs and Government Response, The Alan Guttmacher Institiute, March 2005.
[12] Conservatives' Agenda Threatens Public Funding For Family Planning, The Alan Guttmacher Institiute, February 2005.
[13] U.S. Policy Can Reduce Cost Barriers to Contraception, The Alan Guttmacher Institute, July 1999.

- The need for family planning services for non-citizen individuals in Washington is significant and continues to grow.[14] Non-citizens are not eligible for TAKE CHARGE, although women may receive post-pregnancy contraceptive care for up to one year through the state-funded Pregnancy Extension program. They may receive sliding-scale contraceptive services through Title X and DOH funded clinics as well as Community and Migrant Health Centers if their income is at or below 200% of the FPL.
- In addition to non-citizens served by Title X, DOH state funds, and the DSHS state funded Pregnancy Extension program, the Washington State Department of Health Family Planning and Reproductive Health Program is currently administering a pilot project to increase access to contraception for the Non-citizen population in Washington State.

[14] Washington State Take Charge Medicaid Section 1115 Demonstration Waiver, 7/1/2003 – 6/30/2004 Annual Report.

Family Support Services

What is the service?

Families with members who have disabilities face numerous challenges. Meeting the needs of a child, parent, or other family member who requires support and assistance to accomplish day to day activities can be an enormous stressor for a family. In addition, families with disabilities often face isolation, lack of resources, and discrimination. In response to these challenges, many families with disabilities have become leaders in the field of family support, not only advocating on behalf of their own members and other families, but providing peer to peer family support and playing significant policy roles in their communities and at the state and national level.

Families need support and information while learning how to best support their loved ones who are living with special needs. The family member may need a variety of therapies and services, from physical, occupational, or speech therapy, to special equipment such as wheelchairs, walkers, adaptive computers, or other services. The individual and the family may benefit from respite, formal and informal family support services, counseling, financial planning advice, mental health and other services.

Several organizations in Washington State provide peer support to parents and siblings of children and youth with special needs and disabilities. Some organizations provide one-to-one peer matching, involvement in ongoing support groups or periodic social or educational gatherings. See also the *Care Coordination* chapter for additional family services provided by public agencies.

How/where is the service provided?

One on One Support:

Washington State Fathers Network http://www.fathersnetwork.org/

- Serves fathers, families, and care providers of children and youth with special needs through resources, support groups, social events, website, regional and state conferences, and newsletters: all events and information services are especially "dad-friendly."
- Fathers Network is a program of the Kindering Center, and is funded by the Children with Special Health Care Needs (CSHCN) Program, Washington State Department of Health; the Paul G. Allen Charitable Foundation, and through private donations.

Washington State Parent to Parent http://www.arcwa.org

- Serves families of children and youth with special needs throughout Washington in a variety of ways, including Parent to Parent peer support and matches, website, resources, and other activities. Helps families make connections with other families whose children have a similar condition and/or are from a similar ethnic background.
- Washington State Parent to Parent is a program of the Arc of Washington and works closely with CSHCN Coordinators, medical home teams, feeding teams, and other

services provided by Washington State Department of Health CSHCN Program. CSHCN Program also provides funding.

- **Sibling Support Project** http://www.thearc.org/siblingsupport/
  The Sibling Support Project is a national project for brothers and sisters of people with special needs. "Sibshops", workshops which provide peer support for siblings of children and youth with special needs, are available through Children's Hospital in Seattle. Generally, the children who participate are ages six to thirteen. ibKids and SibNet are free email listserves.

Resource and Information Services:

Adolescent Health Transition Project (AHTP) http://depts.washington.edu/healthtr/

- Provides information and resources to help youth and young adults with special needs transition to adult health care. Provides information on other services necessary for successful transition to all aspects of adult life. The Washington State Adolescent Health Transition Resource Notebook is a great resource available on the website.

The Arc of Washington http://www.arcwa.org/

- Promotes the education, health, self-sufficiency, self-advocacy, inclusion and choices of individuals with developmental disabilities and their families, including serving as manager for the Washington State Developmental Disabilities Endowment Trust Fund. Resources and information available for youth and adults as well as children.

Washington Parents are Vital in Education (PAVE) http://washingtonpave.org

- Bi-lingual/bi-cultural staff work with families, individuals with disabilities, professionals, and community members in all walks of life and with all types of disabilities. Maintains a free lending library of books and video tapes, a quarterly newsletter (PAVE Pipeline), a toll-free telephone number, free and low cost materials in a variety of formats and languages, and provides a variety of training and programs.

Family Educator Partnership Project (FEPP) http://www.arcwa.org

- In many school districts in Washington, FEPP creates partnerships between families, educators, and community agencies in order to support children and youth who need special education services.
- Partnership Team Training promotes shared leadership within a school district to bring positive, proactive approach to planning services for children with disabilities.

National Family Voices http://www.familyvoices.org

- Family Voices is a national, grassroots clearinghouse for information and education about the health care of children with special needs. Their belief in the strength of families is

inspiring: "We all come from families. Families are big, small, extended, nuclear, multi-generational…families have strengths that flow from individual members and from the family as a whole."

Eligibility

All families are eligible and welcome to access support and resources, regardless of income, age, ethnicity, or other demographic features. Some programs are targeted to specific populations, for instance siblings, or fathers.

Who is receiving the Service?

We don't have routinely collected data on how many people are receiving family support services, but we know that there are approximately 211, 000 children with special health care needs in Washington State. About 177,000 Washington State households include a child with special health needs.

Issues/Concerns

- Family support is an essential feature of caring for children and youth with special health care needs. It should not be limited to income eligibility criteria. All families, regardless of income, education, geographical location, and other demographics, need support.

- Culturally competent family support for ethnically diverse populations is inadequate. Trained ethnic outreach coordinators and cultural brokers are needed to provide better services for families from culturally diverse backgrounds. Funding is needed to make this happen.

- Providers, including doctors, case managers, school nurses, and teachers benefit from knowing more about family support services available. When professionals know what is available, they are more inclined to refer families to support.

- Family centered care and support comes through partnerships between families and professionals. Partnership between families and providers is an important area for continued work and development.

The list of organizations in this document is an overview of major sources of support and information. For more information, see the document "Starting Point," available at http://www.cshcn.org.

Financial Assistance for Needy Families

What is the service?

- Washington State provides financial assistance for needy families primarily through the Temporary Assistance for Needy Families (TANF) Program and the State Family Assistance Program (SFA) administered by the Department of Social and Health Services Economic Services Administration.
- TANF, formerly AFDC (Aid to Families with Dependent Children), is a federal welfare program providing a temporary monthly grant and medical assistance to eligible children under age 18 and their needy caretaker relatives.
- SFA was established by the Washington State Legislature to provide financial assistance to families who would no longer be eligible for TANF due to federal Welfare Reform legislation. This program mirrors TANF. The TANF eligibility requirements for immigrants do not apply to this program. All other TANF rules apply.
- Other assistance programs administered by the Economic Services Administration include the Diversion Cash Assistance Program for families with a short term need, Refugee Cash Assistance for refugees or asylees who have resided in the US for 8 months or less, and the Additional Requirements-Emergent Needs program for TANF and Refugee Cash Assistance grant families experiencing housing and utility emergencies. The Economic Services Administration description of all assistance programs is available at: http://www1.dshs.wa.gov/esa/2004briefingbook.htm
- Most TANF/SFA families are required to participate in the *WorkFirst* Program which emphasizes gaining work-based skills to become self-sufficient. It was implemented in 1997 and combines state and federal funding for services.
- Four *WorkFirst* partners and state agencies provide services in collaboration with many business and community organizations. They include: Department of Social and Health Services (DHHS), the Employment Security Department (ESD), the State Board for Community and Technical Colleges (SBCTC), and the Department of Community, Trade and Economic Development (CTED).[1]

  The services they provide include:

DSHS
- First and ongoing contact
- Determines eligibility
- Provides orientation and determines case manager assignment
- Provides monthly cash assistance

ESD
- Provides job placement
- Provides job search workshops and fairs

SBCTC
- Provides job skill and advancement training through 34 colleges/technical schools around state

CTED
- Promotes business, planning, and partnering within community
- Provides Community Jobs program

- *WorkFirst* Services include:[1]
  - Vocational counseling, training and skill development

- Job placement
- Parenting classes and help paying for childcare
- Nutrition and health care
- Work clothes or uniforms
- Assistance seeking, preparing for, and adjusting to promotions

- *WorkFirst* Website: http://www.workfirst.wa.gov

How is the service provided?

- For monthly cash assistance, families complete a single application online or in person at one of 57 Community Service offices (CSO) across the state.
- CSO staff also link families with programs at federal, state, and local levels, including: child support, food stamps, tuition assistance, medical assistance, working child care connections, etc.[1]
- Most TANF families are required to participate in the *WorkFirst* program.

Eligibility

- Washington State residents who are pregnant or responsible for the care of children who meet income and resource requirements and citizenship requirements are eligible.
- Income and resource requirements are defined by federal and state laws and income limits vary by the size of family.[2]
- Most families are limited to 60 months of cash assistance in their lifetime.
- Federal government allows 20% of state caseload to be exempt from 60 month lifetime limit if there are: extenuating circumstances, full-time participation, or Child Safety Net sanction in place.[1]
- Eligibility is reviewed at least every 6 months, and continues until the client becomes ineligible.
- Families moving from other states to Washington receive the same benefits as Washington State residents.
- The Eligibility A-Z Manual provides administrative rules and procedures for staff to determine eligibility for people applying for cash, food and medical assistance in Washington State at http://www1.dshs.wa.gov/esa/eazmanual/.

Who is receiving the service?

Income Assistance (AFDC/TANF) Average Monthly Caseload[3]

Year	1997	1998	1999	2000	2001	2002	2003	2004
Caseload	95,334	85,524	67,256	58,796	54,579	55,068	54,654	55,607

[1] Washington Workfirst, "Washington State's Temporary Assistance for Need Families (TANF) State Plan (Biennial Review December 23, 2002". Website: http://www.workfirst.wa.gov/about/planbody.pdf . Accessed 5/10/05
[2] Washington State Department of Social and Health Services, "Eligibility A-Z Manual, Cash Assistance". Website: http://www1.dshs.wa.gov/esa/eazmanual/Sections/Stds4Cash.htm. Accessed 6/2/05
[3] Washington State Office of Financial Management. "Washington Trends: Income Assistance (AFDC/TANF) Average Monthly Caseload ". Website: http://www.ofm.wa.gov/trends/htm/fig404.asp Accessed 8/19/05

- Once 60 month limit is reached, reevaluation of need takes place, and benefits are extended if needed.
- As of June 2004, approximately 6% of average caseload was receiving extended benefits past the 60 month limit, which is far from the 20% level allowed federally.[4]
- Since 1997 *WorkFirst* reform, welfare levels have dropped by approximately 40% from 97,000 in 1997 to 58,000 in April 2005.

Average Monthly Assistance Amount and Members Receiving TANF/GA/SSI[5] (in 2003)

Description	
Percent of Washington households with member receiving TANF assistance	5.1% (N=122,143)
Median Monthly Cash Assistance	$406

- Median *WorkFirst* wage for single parent with two children (as of February 2005) was $8.50 per hour. This figure does not incorporate child support services that go directly to the parents, irrespective of whether the parent is receiving cash assistance.[6]

Issues/concerns

- Washington's *WorkFirst* program is described as "innovative assistance plan", with a dramatic decrease in welfare recipients since 1997.[5]
- As of Spring 2005, new measurement methods are being tested in an effort to improve federal participation rates.[7]
- The Internal Revenue Service wants taxpayers to be aware of additional tax refund options through the Earned Income Tax Credit (EITC). Up to $4,300 per family is available to families with children earning below $34,458 per year.[8]
- DSHS is working to improve monitoring and documenting of TANF services.[9]
- Washington State has historically provided TANF benefits for Washington tribes. In 2002, Port Gamble S'Klallam assumed responsibility for TANF assistance for tribe members. Other tribes are also assuming TANF responsibilities.[10,11]

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[4] Economic Services Administration, Department of Social and Health Services, "ESA Briefing Book for State Fiscal Year 2004". Website: http://www1.dshs.wa.gov/ESA/2004briefingbook.htm. Accessed 8/19/05.

[5] 2004 Washington State Population Survey; Office of Financial Management (OFM), Department of Health, Department of Social and Health Services. Website: http://www.ofm.wa.gov/sps/2004/tabulations.asp . Accessed 5/10/05

[6] Washington *WorkFirst*, "2005 Monthly Earnings and Benefits for Single Parent with 2 children". Website: http://www.workfirst.wa.gov/about/workpays.htm. Posted 2/05

[7] Washington *WorFirst*, State Staff Briefings 2005, "Actual Hours Release Dates Announced". Website: http://www.workfirst.wa.gov/statestaff/briefings.htm. Accessed 5/26/05

[8] Washington *WorkFirst*, Press Releases, "Don't Overlook Earned Income Tax Credit, Amended Returns Can Bring Big Payments". Website: http://www.workfirst.wa.gov/eitc/eitcpressrelease0305.htm. Posted 3/25/05.

[9] Washington State Department of Social and Health Services, "DSHS Working to Comply with Newly Issued Audit Findings but Says Some Exceed Legal Requirements of Funding", Website: http://www1.dshs.wa.gov/mediareleases/2005/pr05019.shtml. Posted 3/8/05

[10] Washington State Department of Social and Health Services, "Port Gamble S'Klallam Becomes First Washington Tribe to offer its own TANF and Child Support Programs", Website: http://www1.dshs.wa.gov/mediareleases/2002/pr02227.shtml. Posted 7/02. Re-posted 5/7/05

[11] Washington State Department of Social and Health Services, "Three South Sound Tribes Reach Agreement to Provide Temporary Assistance for Needy Families". Website: http://www1.dshs.wa.gov/mediareleases/2004/pr04241.shtml. Posted 9/04; Re-posted 5/7/05

First Steps Services

What are the services?

- First Steps helps low-income pregnant women get the health and social services they need. Services are delivered by a network of both public and private agencies across Washington State. The program is managed collaboratively by the Washington State Department of Social and Health Services (DSHS) and the Washington State Department of Health (DOH). DSHS provides Medicaid funding for all First Steps services. DSHS and DOH jointly share administration of the program through an inter-agency agreement and delegation of authority.
- Goals of the First Steps Program
    - provide interventions as early in pregnancy as possible
    - promote early and continuous prenatal care
    - reduce incidence of low birth weight infants
    - decrease health disparities among vulnerable populations
    - reduce the number of unintended pregnancies
    - reduce the number of repeat pregnancies within two years of delivery
    - increase the initiation and duration of breastfeeding
    - reduce tobacco use during pregnancy and pediatric exposure to second-hand smoke
    - reduce the incidence of SIDS
    - reduce infant mortality rates
    - increase self-sufficiency of the mother and family unit
- In 2003, First Steps provided prenatal care and/or delivery services to 36,118 women. Of these women, approximately 71% received maternity support services.[1]
- There are three components of First Step support services:
    - Maternity Support Services: These are preventive health services designed to supplement medical visits and include screening, assessment, interventions, education, case management, and counseling. Services are provided in an office or the client's home by a multidisciplinary team of nurses, dietitians, behavioral health specialists and community health workers. The number and type of visits provided depends on the needs of the woman and her family but the total of all visits cannot exceed 15 hours. Interventions are based on identified risk factors and focus on improving pregnancy, early parenting outcomes, and self sufficiency.
    - Infant Case Management: The goal of Infant Case Management is to improve the birth parents' (and family's) self sufficiency in accessing existing social and health resources in the community to meet their immediate needs. These services are limited to 1) acting on the client's behalf in order to ensure the client receives needed services (advocacy); 2) networking and/or collaborating among staff of different agencies/programs to connect clients to services and avoid duplication (linkages); and 3) providing information to clients to assist them in receiving medical, social, educational, or other services (referral).

[1] Cawthon, L. Maternity Support Services and Maternity Infant Case Management Use by Women with Medicaid-paid Births in 2003, Washington State Department of Social and Health Services First Steps Database, 4/18/05.

- Additional Support Services include childbirth education, childcare, breastfeeding consultation, tobacco cessation counseling, family planning (post delivery), and access to a public education and referral toll-free line through the Healthy Mothers, Healthy Babies Coalition. (For additional information, see the *Healthy Mothers, Healthy Babies Services* Chapter.)

- First Steps Website: http://fortress.wa.gov/dshs/maa/firststeps

How/where is the service provided?

- Women learn about First Steps services through multiple sources, including when they have a pregnancy test, when they apply for medical coupons, when they visit their health care provider, when applying for the Women, Infants and Children Supplemental Nutrition Program (WIC), or by contacting the toll-free Healthy Mothers/Healthy Babies information line.
- Women can apply for First Steps by visiting their local DSHS Community Service Office (CSO). They can call 1-800-322-2588 for more information, or can access the CSO online at https://wws2.wa.gov/dshs/onlinecso/findservice.asp
- First Steps support services are provided by approximately 92 private and public agencies in over 150 sites throughout the state. All agencies either provide or partner with other agencies to provide services of the Women, Infants and Children Supplemental Nutrition Program (WIC). (For additional information, see the *Nutrition Services* Chapter.)

Eligibility

- All pregnant women in the State of Washington whose income is at or below 185% of the Federal Poverty Level (FPL) are eligible for Medicaid-paid maternity care, including First Steps support services.
- Maternity Support Services may be provided only during the "maternity cycle," which means from the onset of pregnancy through the end of the month in which the 60th postpartum day occurs.
- Infant Case Management Services are restricted to high risk infants less than one year old living with his or her biological parent whose income is up to 200% FPL. Qualifying criteria for a high risk infant include physical, developmental, or safety issues that impact health and development.

Who is receiving the service?

Of the 36,118 Washington women (45.6% of all births) who received Medicaid coverage for their prenatal care and/or delivery, 25,521 (70.7% of Medicaid Deliveries) received First Steps support services in 2003.[1] In 2003, 56% of First Steps support services were public health nursing services, 19% were behavioral health services, 14% were nutrition services and 10% were community health worker visits.[2] The table below shows the numbers of teen women who received any First Steps support services as a percent of Medicaid deliveries, as well as the breakdown by race/ethnicity.

[2] Conlon, D. Medical Assistance Administration First Steps Procedures by Procedure Code and Date of Service, Fiscal Years 2003-2005 Dates of Service. Washington State Department of Social and Health Services, 7/29/2005.

Washington Women with Medicaid-paid Births in 2003
Who Received First Steps Support Services [1]

	Non-Medicaid Deliveries		Medicaid Deliveries		First Steps Support Services	
	#	% Births	#	% Births	#	% Medicaid Births
State Total	43,119	54.4%	36,118	45.6%	25,521	70.7%
Women ≤ 17 yrs	147	7.2%	1,881	92.8%	1,606	85.4%
Women 18-19 yrs	649	13.8%	4,070	86.2%	3,135	77.0%
White, Non-Hispanic Women	32,908	63.5%	18,945	36.5%	11,743	62.0%
Hispanic Women	3,157	23.9%	10,048	76.1%	8,537	85.0%
African American Women	933	34.3%	1,788	65.7%	1,444	80.8%
American Indian Women	303	23.2%	1,004	76.8%	548	54.6%
Asian Women	3,892	67.9%	1,844	32.1%	1,420	77.0%
Pacific Islander Women	199	35.1%	368	64.9%	272	73.9%
Women reporting more than one race	1,031	42.9%	1,373	57.1%	983	71.6%

Medicaid-paid births include women who delivered a live birth or fetal death greater than 20 weeks whose deliveries were covered by Medicaid. A delivery is considered covered by Medicaid if the mother received Medicaid-paid prenatal or delivery services or if she was enrolled in Medicaid managed care for at least 3 of the 6 months prior to delivery.

Issues/concerns

- There are persistent issues with early linkage and referral of pregnant women to First Steps programs from the community service offices, including women at high risk for poor outcomes.
- Long term sustainability of this program will depend on innovative restructuring so that intensity of services are matched appropriately to individual client needs.
- Depression during the perinatal period has been identified as a significant risk factor that is affecting the long term health of the pregnant woman, her infant and family, yet there are inadequate services in communities throughout Washington to meet the needs of these women.
- Eligibility criteria limit the ability of most women to obtain medical care after two months post delivery.

Genetic Services

What is the service?

Publicly funded genetic services in Washington include support for genetic counseling services at nine of the 16 regional genetics clinics, the Regional Laboratory for the Diagnosis of Inborn Errors of Metabolism at Children's Hospital and Regional Medical Center (CHRMC), the Phenylketonuria (PKU) Clinic at University of Washington (UW), cytogenetics [1] testing for eligible patients, and prenatal diagnosis genetic counseling for Medicaid clients. In addition, all infants born in the state are screened for certain preventable disorders, many of which are genetic, through the Department of Health's statewide Newborn Screening Program. Affected infants are connected with specialty preventive care. Screening is funded by a fee charged to the parents through the birthing facility; clinical care receives funding through many sources, largely private insurance and Medicaid, with some support from Title V and screening fees.

- The Department of Health's Genetic Services Section (GSS) provides some of the funding to nine regional genetics clinics through the Maternal and Child Health Block Grant (Title V) and state general funds. Eight of the nine funded clinics provide prenatal genetic services, including diagnostic screening, evaluation, counseling, and/or treatment relating to the outcome of a pregnancy. All nine funded clinics provide clinical genetic services, including diagnostic screening, evaluation, treatment, and determination of carrier status and/or counseling delivered to a clinical genetic patient and/or members of the same family. All funded clinics also provide education about human genetics and access to genetic services to health professionals and the lay public in Washington State.
- Funding for the CHRMC laboratory helps support diagnosis of inborn errors of metabolism and provides diagnostic confirmation for several conditions identified through newborn screening.
- Title V, state, and local funds support the UW PKU Clinic, which provides diagnosis, assessment, genetic counseling, and consultation for ongoing dietary management and health supervision, as well as evaluation of treatment outcomes to all children with PKU and their families.
- GSS maintains an interagency agreement with Health Recovery Services Administration (formerly Medical Assistance Administration) to provide required matching state funds for the reimbursement of prenatal genetic counseling services for Medicaid clients.
- Individuals, including non-citizen immigrants, can receive financial assistance from GSS for cytogenetics testing based on a sliding scale.
- In accordance with state law, the Department of Health Office of Newborn Screening conducts statewide screening of all newborns for nine congenital disorders.
- Websites:
    - Genetic Services Section http://www.doh.wa.gov/cfh/mch/Genetics/Regional_Genetics_Clinics.htm
    - Newborn Screening http://www.doh.wa.gov/nbs

[1] Cytogenetics is the study of normal and abnormal chromosomes.

How/where is the service provided?

- In Washington State, Title V provides funding to the following genetics clinics: Blue Mountain Genetics Clinic in Walla Walla; CHRMC (lab and clinic) in Seattle (also serving a clinic in Bellingham); Inland Northwest Genetics Clinic in Spokane, Mary Bridge Children's Health Center in Tacoma, UW Medical Genetics Clinic in Seattle (also serving a clinic in Everett), UW PKU Clinic in Seattle, and Yakima Valley Memorial Hospital in Yakima (also serving Central Washington Hospital in Wenatchee).
- In addition, genetic services can also be accessed at Swedish Hospital (Seattle), Madigan Hospital (Tacoma), Group Health Cooperative, Kadlec Hospital (Tri-Cities), Obstetrix (Auburn and Tacoma) and Evergreen Hospital.
- Newborn screening specimens are collected at hospitals and clinics. Specimens are sent to the Newborn Screening Program's laboratory in Shoreline, Washington.

Eligibility

- Regional Genetics Clinics receiving Title V and state funds must accept all referrals.
- Cytogenetics: Men and women who are not eligible for Medicaid or other financial assistance programs, with family incomes at or below 200% of the FPL, are eligible for financial assistance. Title V and DOH state funded cytogenetics services are charged on a sliding fee scale for clients with incomes between 100% and 200% FPL. Clients whose income is at or below 100% FPL receive services at no charge to the client.
- Prenatal genetic counseling is provided as fee-for-service for any pregnant woman and/or newborn covered by Medicaid, including Healthy Options through 90 days after birth when it is medically indicated.
- Newborn screening is required for all newborns by law. Parents can refuse on religious grounds only.

Who is receiving the Service?

Clients receiving prenatal and clinical genetic services in Washington at clinics receiving some public funding, 2004; cytogenetics tests supported in part by Title V funds, 2004.

	Prenatal[2]		Clinical[3]		Cytogenetics[4]	
	Number	**Percent**	**Number**	**Percent**		
Sex						
Female	670	100%	1861	55%	In 2004, GSS provided financial assistance for cytogenetic testing for 2 patients.	
Male	n/a	n/a	1501	44%		
Ambiguous	n/a	n/a	17	1%		
Total	670	100%	3379			

[2] Unduplicated clients served in 2004 at clinics receiving some funding from Title V, as reported in the Washington State Genetic Services Minimum Data Set, 2004.
[3] Unduplicated clients served in 2004 at clinics receiving some funding from Title V, as reported in the Washington State Genetic Services Minimum Data Set, 2004.
[4] Unduplicated clients who received financial assistance for cytogenetics in 2004, Washington State Genetic Services Section 10/05.

Age					
<17	19	3%	471	14%	
18-19	24	4%	1103	32%	
20-24	99	15%	536	16%	
25-34	182	27%	272	8%	
35+	342	51%	333	10%	
Unknown	4	n/a	664	20%	
Race					
White	447	67%	2136	63%	Not Available
White/ Hispanic	28	4%	51	1.5%	
Black	2	0%	64	2%	
Black/ Hispanic	0	0%	2	0%	
Asian/ Pacific Is.	16	2%	105	3%	
Native American	20	3%	42	1%	
Mexican	147	22%	151	4.5%	
Other	4	1%	25	1%	
Other/ Hispanic	1	0%	36	1%	
Unknown	5	1%	767	23%	
Total	**670**	**100%**	**3379**	**100%**	

- In 2004, 77,774 infants (or 99.6% of births reported to the Newborn Screening Program) were screened for the required congenital disorders (does not include births at military facilities).

Issues/Concerns

- Title V funded clinics are confronting the increased cost of genetic services, and the increasing numbers of uninsured individuals, in the face of potential budget cuts.
- The increasing identification of genetic disorders and emerging screening and diagnostic techniques will soon outstrip the state's capacity to ensure appropriate access to high quality, comprehensive clinical and laboratory genetic services.
- At both the state and national levels, Medicaid expenditures continue to grow despite current cost containment efforts. Continuing budget shortfalls and reductions in services consistent with available resources are predictable.

Health Insurance

Introduction

- Washington residents with health care coverage receive it from a variety of sources including employers, individual plans, and the government.
- In 2004, 69% of adults ages 19-64 obtained health insurance through their own or their spouse's employer or union. During the same time, 58% of all children ages 0-18 and 62% of children ages 10-18 received health insurance through their parents' employer.[1]
- Similar to national trends, employer-based insurance premiums in Washington have risen dramatically in the past decade. In addition to premiums, those with employer-based coverage are being required to pay out-of-pocket for services, either with deductibles or co-payments.

Uninsured

- In 2004, approximately 606,000 Washington residents or about 10% of the population was uninsured, up from about 8% in 2002.[2] This change was not statistically significant.
- Washington residents at increased risk of being uninsured include the poor or near-poor, those who live in rural areas, non-citizens, those who report fair or poor health, or those who report a disability.[3]
- Seventy-nine percent of survey respondents without health insurance reported cost as the barrier to their having insurance.[4]
- In 2004, approximately 98,000 children ages 0-18 or 6.0% of the child population was uninsured, up from 4.5% in 2002. This change was not statistically significant.[2]

Health and Recovery Services Administration (formerly Medical Assistance Administration)

- Health and Recovery Services Administration (HRSA) of the Washington State Department of Social and Health Services provides managed-care and fee-for-service health care insurance to low-income people in Washington primarily through a federal/state Medicaid partnership.
- Low-income pregnant women with household incomes up to 185% of the federal poverty level (FPL), (a monthly income of $2,984 for a family of four in 2005), are eligible for medical coverage.
- Children in households with incomes below 200% FPL (a monthly income of $3,225 for a family of four in 2005) are eligible up to age 19.
- Members of families receiving cash assistance (TANF) and people with disabilities are also eligible for coverage.
- An extensive array of services is covered, including: inpatient and outpatient care, physician services, lab and x-ray, nursing facility services, family planning, home health

[1] Gardner, E. Health Insurance by Work Characteristics: 2004. 2004 Washington State Population Survey Research Brief No. 34. Washington State Office of Financial Management, April 2005 and E. Gardner, personal communication.
[2] Gardner, E. The Uninsured Population in Washington State. 2004 Washington State Population Survey Research Brief No. 31 (revised). Washington State Office of Financial Management, February 2005.
[3] Gardner, E. Characteristics of the Uninsured: 2004. 2004 Washington State Population Survey Research Brief No. 32. Washington State Office of Financial Management, February 2005.
[4] 2004 Washington State Population Survey, Medical Insurance Data Tabulations posted at http://www.ofm.wa.gov/sps/2004/tabulations.asp . Accessed 6/14/05.

and nurse-midwife services, additional medically necessary services, outpatient drugs, durable medical equipment, dental services, physical, speech and occupational therapy, preventive care and well-child visits.

- Currently, no cost-sharing is required for Medicaid clients, although monthly premiums for those children covered in Washington whose coverage is not mandated by federal law have been proposed in the past few years.
- Six-month eligibility reviews for children were instituted in April 2003 resulting in cost-savings but also children being dropped from Medicaid. In April 2005, the state reverted to 12-month continuous eligibility for children on Medicaid.
- 36,118 women who gave birth were covered by Medicaid in 2003, 45.6% of all Washington State births.[5]
- 664,983 children ages 0-18 received Medical Assistance at some point in 2003, 43.7% of all children ages 0-18 in Washington State.[6] About 33% of children were receiving Medical Assistance at any given time.[7]
- *Healthy Options* is the Medical Assistance managed-care program that included 8 health plans in 2003. *Healthy Options* covered 48.1% of Medicaid-paid births, and 73% of children ages 0-18 on Medicaid in 2003.[8,9]
- Website: http://fortress.wa.gov/dshs/maa

Children's Health Insurance Program (CHIP)

- The Children's Health Insurance Program provides insurance to children in families whose income is too high for Medicaid but still falls within CHIP's guidelines.
- Children in households with incomes from 200-250% FPL (a monthly income between $3,226 and $4,032 for a family of four in 2005) are eligible up to age 19.
- Benefits and choice of health plans are the same as for Medicaid.
- Monthly premium of $15 per child, up to $45 maximum per family.
- Approximately 13,000 children receive CHIP each month, 84% of whom are enrolled in managed care.
- Website: http://fortress.wa.gov/dshs/maa/CHIP/Index.html

Basic Health

- The Basic Health Plan is a reduced-cost, state-sponsored health coverage program administered by the Washington State Health Care Authority.
- The Basic Health Plan contracts with five health plans across the state.
- Services covered include hospitalization, provider visits, emergency services, and prescriptions.
- The Basic Health Plan has a sliding-scale premium based on age, income, family size, and health plan selected.
- Co-payments for preventive-care services are required.

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[5] Cawthon, L. Eligibility Status for Washington Women with Medicaid-Paid Births in 2003, Washington State Department of Social and Health Services, First Steps Database, 2/23/05.
[6] Washington State Department of Social and Health Services, Research and Data Analysis Division, 2003 Client Data 2003, http://www1.dshs.wa.gov/rda/research/clientdata/2003/default.shtm. Accessed 8/12/05.
[7] Gardner, E. Washington State Office of Financial Management, personal communication, August 2005.
[8] Cawthon, L. Managed Care Enrollment Status for Washington Women with Medicaid-Paid Births, 1993-2003, Washington State Department of Social and Health Services, First Steps Database, 2/23/05.
[9] DSHS Human Services in Your County, July 2002-June 2003, Washington State Department of Social and Health Services, Research and Data Analysis Division. Accessed from http://www1.dshs.wa.gov/excel/ms/rda/2003/state.xls 6/01/05.

- $150 annual deductible and $1,500 annual out-of-pocket maximum per person (maximum applies to coinsurance charges only). Enrollee co-payment or coinsurance applied to most services.
- As of December 2004, included 97,273 enrollees; 81,605 adults and 15,668 children. Over 50% had family incomes less than 100% FPL.[10]
- Website: http://www.basichealth.hca.wa.gov/

Basic Health *Plus*

- The Basic Health *Plus* Program is coordinated by Washington State Department of Social and Health Services and Washington State Health Care Authority for children who are Medicaid eligible and whose parents are enrolled in Basic Health.
- Children receive expanded health benefits that are the same as those for clients covered by Healthy Options (Medicaid) plans.
- No premiums or co-payments required.
- In December 2004, 26,957 children were covered by Basic Health *Plus*. These children are reflected in the 664,983 children covered by Medicaid.
- Website: http://basichealth.hca.wa.gov/plus.shtml

Individual Insurance Market

- Individuals denied health insurance can enroll in the Washington State Health Insurance Pool (WSHIP), which has three benefit plans of varying structure, deductibles, and payments available to consumers.
- WSHIP premiums may be reduced for enrollees ages 50 to 64 whose gross income is no more than 300% FPL.
- Website: http://www.wship.org/

Issues/Concerns

- As health care costs increase, there is an increasing burden on employers who provide health insurance to employees. This has led to employers cutting back on coverage and raising employees' share of costs, especially for covered family members. As affordability has decreased, more people have sought public funding.

[10] Basic Health Enrollment Summary, December 2004. Washington State Health Care Authority. June 2005.

Healthy Mothers, Healthy Babies Information and Referral Services

What is the service?

- Healthy Mothers, Healthy Babies (HMHB) is a private, not-for-profit organization that provides *a single point of access* for information and referral services to families in areas such as health insurance, nutrition resources, family planning, child care, and immunizations.
- HMHB receives public funding from the Washington State Department of Health, Department of Social and Health Services and the Health Improvement Partnership of Spokane to operate four statewide, toll-free information and referral lines.
- The Maternal-Child Health line provides eligibility screening and referrals to Medicaid and WIC, as well as referrals and health education materials regarding pregnancy, prenatal care, maternity support, childbirth, and breastfeeding.
- HMHB provides eligibility, screening, information, and referrals to Medicaid and the State Children's Health Insurance Program through the Healthy Kids Now! line.
- The Family Planning/TAKE CHARGE line provides family planning information and referrals for men and women to TAKE CHARGE providers.
- In 2005, HMHB added the Family Food Hotline which provides eligibility, screening and application connections to WIC and the Basic Food program (food stamps), and information and referrals to food banks and the summer meals program.
- HMHB builds partnerships and coalitions within the maternal and child health community. These collaborative partnerships build bridges between stakeholders and service providers to help shape the best services and policies for pregnant women, children, and families in Washington State. These include the Immunization Action Coalition of Washington and the Breastfeeding Coalition of Washington.
- Website: www.hmhbwa.org

How/where is the service provided?

- HMHB operates four toll-free statewide information and referral lines:
    - Maternal-Child Health 1-800-322-2588
    - Healthy Kids Now! (SCHIP) 1-877-543-7669
    - Family Planning/Take Charge 1-800-770-4334
    - Family Food Hotline (Food Stamps) 1-888-4-FOOD-WA (888-436-6392)

- HMHB's bilingual information and referral specialists screen callers for eligibility and assist them in applying for and accessing Department of Health and Department of Social and Health Services programs and services, including First Steps (Medicaid-funded prenatal and delivery care and maternity support services), WIC, Children with Special Health Care Needs, CHILD Profile Immunization Program, TAKE CHARGE, and other Family Planning services, Children's Health Insurance Program, and Basic Food (food stamps). For languages other than English and Spanish, HMHB uses the AT&T Language Line interpreter service.
- Beyond providing information and referral services, HMHB staff help families understand eligibility criteria and how to apply for and enroll in programs, and the services provided by each program and organization.

- HMHB's localized, multi-language health education materials uniquely serve diverse populations throughout the state, reducing cultural and linguistic barriers.

Who is eligible for the services?

- HMHB's services are available to all residents of Washington State.
- Although HMHB primarily serves low-income pregnant women and families with children under age five, calls on HMHB's toll-free lines, and requests for health education materials, are received from all socio-economic and racial/ethnic groups.

Who is receiving the service?

- During 2004, approximately 53,000 people called HMHB's toll-free lines.
    - 32,773 calls to Maternal-Child Health line
    - 13,527 calls to HealthyKidsNow! Line
    - 6,235 calls to Family Planning/TAKE CHARGE line
- More than 90% of callers were Medicaid-eligible (i.e., with incomes below 185% of the Federal Poverty Level (FPL) for pregnant women, or below 200% FPL for children), although only about half of those eligible were already enrolled in Medicaid. Callers were primarily families with children under age five, and pregnant women.
- More than 28,000 pregnant women received a copy of HMHB's Prenatal Care and Baby Book which is available in eight languages, and many thousands more obtained other health education materials from HMHB.

Issues/concerns

- The Department of Health's ability to continue to obtain federal matching support of HMHB at current levels is being threatened. HMHB's contract with DOH is funded through a variety of sources, including state funds and federal Maternal Child Health block grant and Medicaid funds. These funding sources are all experiencing new demands and possible cuts. Deep cuts would threaten HMHB's ability to deliver services.
- Medicaid clients call HMHB with questions about obtaining health care, because many health care providers no longer accept medical aid coupons. There is no universal source of information about health care access in the state, but the sources available all indicate local variation iN access to care for Medicaid eligible recipients. Access is particularly difficult in rural areas, and for families seeking dental care for their children, obstetric and gynecologic care, and other specialist care.
- The barriers which prevent families from accessing needed programs and services have been well documented over the years. Those barriers have been exacerbated by increasing costs for housing and other essentials. Rapidly rising gasoline costs, in particular, make it more difficult than before for families to access needed services, especially in rural areas of the state.
- The state ranks tenth in the nation in food insecurity. Many families, who are already availing themselves of all food programs and services, still find their families hungry at the end of the month. The "safety net" does not provide enough for families to "make ends meet."

Immunization Program CHILD Profile

What is the Service?

- The CHILD Profile and Immunization Program (CPIP) is committed to the following:
  1. Preventing the occurrence and transmission of childhood, adolescent, and adult vaccine preventable disease.
  2. Increasing utilization of preventive health care for children birth to age six.
- Websites:
  - Immunization Program: http://www.doh.wa.gov/cfh/immunize/
  - CHILD Profile: http://www.childprofile.org
- CPIP provides six primary services to the public, healthcare providers, and state and local health agencies:

Function	Description
Lifetime Immunization Registry	▪ Provides healthcare providers with access to a repository of data to make immunization decisions and improve immunization services. ▪ Assures public health has the information needed to protect the public from vaccine preventable diseases.
Surveillance	▪ Reaches and maintains federal and state immunization coverage level goals, and maintains disease reporting and outbreak control activities. ▪ Works with the DOH Epidemiology Office to provide technical assistance for outbreaks and disease surveillance.
Vaccine Distribution	Ships publicly purchased vaccines to local health jurisdictions who distribute the vaccine to local healthcare providers for administration to children age 0-18 years old.
Clinical Consultation and Education	Provides nursing consultation, education, and technical assistance to nurses and support staff at local health jurisdictions and private health care provider offices. Information addresses clinical immunization practices, vaccine management, and outbreak control measures.
Quality Assurance	Provides clinic-based assessment in private and public practices to assist healthcare providers in identifying opportunities where immunization coverage levels can be provided.
Health Promotion and Communication	▪ Provides information to the public that supports and assists them in making health care decisions. ▪ Distributes over 2 million immunization-related informational and educational materials to parents, adults, and healthcare providers annually. ▪ Provides parents of children birth to six with age-specific reminders of the need for well-child checkups and immunizations and information on development, safety, nutrition, and other parenting issues.

Funding

- State supplied vaccines are purchased with a blend of federal Vaccines for Children (VFC) Program funding, 317 federal funds, and general state funds.

- Registry and health promotion materials are funded by federal Vaccines for Children (VFC) Program funding, 317 federal funds, MCH block grant, Title XIX funding, general state funds, and public partnerships.

How/where is the service provided?

Immunizations	**Health Promotion**
▪ Vaccines are available from contracted primary care providers, local health departments, rural health clinics, and federally qualified health centers throughout Washington. ▪ The majority of children are served by their primary care providers (approximately 75%). Local health jurisdictions provide about 6% of immunization services, with the remainder obtained from federally qualified health centers, community and migrant health centers, rural health clinics, and other public health care sites. ▪ As of July 1, 2005, DOH has contracts with 1,155 public and private health care providers statewide. ▪ Over 55% of all contracted providers are enrolled with the CHILD Profile Immunization Registry.	▪ Health promotions materials are mailed to parents of children ages birth through six. o As of August 2005, 81% of parents of children birth to age six were mailed the CHILD Profile health promotion materials. o Currently, 5.5% of children ages birth to six receive Spanish-language materials. (5.5% of the total number of children receiving mailings). o Approximately 1.4 million materials are mailed to parents each year.

Eligibility

- Routine childhood vaccines are available at no cost to all children in Washington State from birth through age 18, regardless of income, race, or other socioeconomic factors.
- Providers may charge non-Medicaid patients a vaccine administration fee, not to exceed $15.60 per dose.
- Any health care provider can contract for free access to the immunization registry.

- All Washington children ages 0 to 6 years old are eligible to receive CHILD Profile health promotions materials.

Who is receiving the service?

Each year, the Immunization Program conducts a one-month survey of all children who receive state-supplied vaccine. The chart below provides the results of the survey conducted yearly from 1999 to 2004. [1]

Washington State Benchmarking Comparison
1999-2004

Vaccines for Children (VFC) Eligibility Categories	**1999** (n=69,316)	**2000** (n=79,100)	**2001** (n=58,022)	**2002** (n=50,969)	**2003** (n=49,488)	**2004** (n=54,062)
Medicaid	28.5%	31.0%	37.2%	37.8%	37.4%	37.1%
Native American	5.4%	4.1%	3.4%	3.2%	3.7%	2.7%
Uninsured	7.1%	6.1%	<.1%	5.9%	8.1%	3.9%
Insured	54.6%	58.8%	59.2%	53.1%	50.8%	55.8%
Under-insured (insurance coverage does not include immunizations)	Not collected	Not collected	Not collected	Not collected	Not collected	0.5%
% VFC Eligible	45.3%	41.2%	40.6%	46.9%	49.2%	44.2%
Age Comparison	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**
0 - 11 months (< 1 year old)	21.4%	23.7%	33.1%	35.2%	34.5%	36.7%
12 - 23 months	9.3%	9.7%	20.2%	19.1%	19.9%	20.9%
24 - 35 months	1.8%	2.2%	5.3%	4.8%	5.5%	6.8%
36 - 47 months	1.5%	1.8%	2.8%	2.9%	3.3%	4.2%
48 - 59 months	4.3%	4.6%	4.2%	4.3%	4.7%	5.7%
60 - 71 months (5 year olds)	11.0%	11.3%	9.2%	9.6%	9.4%	4.3%
6 – 9 year olds	8.8%	8.9%	6.0%	5.7%	5.0%	7.2%
10 – 14 year olds	32.6%	30.6%	14.6%	14.7%	13.0%	10.1%
15 – 18 year olds	9.3%	7.2%	4.6%	3.7%	4.7%	4.1%

[1] These data are the result of a non-scientific survey and are based on self-reported information from parents and guardians

The Immunization Registry is a statewide system that serves parents and healthcare providers in every county in Washington State. There are currently over 20 million vaccination records in the registry. The Immunization Registry has set a goal to enroll 62% of public and private healthcare providers in the Registry by 12/31/05. This chart displays the progress made toward this goal, as of 12/31/04.

Public and Private Healthcare Providers

County	Total # of Sites in County[1]	% of Total Sites Enrolled	# of Public Sites	% of Public Sites Enrolled	# of Private Sites	% of Private Sites Enrolled
Adams	4	100%	3	100%	1	100%
Asotin	3	0%	1	0%	2	0%
Benton Franklin	48	44%	7	100%	41	34%
Chelan Douglas	15	93%	3	100%	12	92%
Clallam	27	52%	7	71%	20	45%
Clark	44	52%	4	100%	40	48%
Columbia	2	100%	1	100%	1	100%
Cowlitz	14	64%	2	100%	12	58%
Garfield	2	50%	1	100%	1	0%
Grant	23	74%	8	88%	15	67%
Grays	24	33%	5	80%	19	21%
Island	15	80%	5	100%	10	70%
Jefferson	7	71%	1	100%	6	67%
Kitsap	41	49%	8	100%	33	36%
Kittitas	7	29%	1	100%	6	17%
Klickitat	4	100%	2	100%	2	100%
Lewis	23	30%	2	50%	21	29%
Lincoln	5	100%	1	100%	4	100%
Mason	8	38%	3	33%	5	40%
Northeast Tri	18	61%	9	100%	9	22%
Okanogan	16	63%	5	100%	11	45%
Pacific	9	78%	3	67%	6	83%
San Juan	7	71%	3	100%	4	50%
Seattle - King	317	56%	52	81%	265	52%
Skagit	23	22%	5	60%	18	11%
Skamania	2	100%	1	100%	1	100%
Snohomish	74	51%	9	89%	65	46%
Spokane	84	54%	10	70%	74	51%

Tacoma - Pierce	121	46%	13	100%	108	40%
Thurston	41	29%	2	100%	39	26%
Wahkiakum	2	100%	1	100%	1	100%
Walla Walla	7	71%	2	100%	5	60%
Whatcom	31	26%	8	75%	23	9%
Whitman	10	40%	2	100%	8	25%
Yakima	50	30%	7	100%	43	19%
Totals	**1128**	**51%**	**197**	**86%**	**931**	**44%**

[1] Total number of sites in the county includes both public and provider sites

Juvenile Justice Services

What is the service?

- Rehabilitation involving vocational, educational, and behavioral health services for youth (8-21 years old) with multiple criminal offenses or serious offense, as determined by the state legislature's determinate sentencing system. This model of services is called the Evidence Based Model, and has been used in Washington since 2000.
- The "Juvenile Offender Sentencing Grid" provides the framework on deciding how juveniles are referred, taking into account whether it's a first offense and the severity.[2]
- Websites:
    - Overview: http://www1.dshs.wa.gov/jra/

How/where is the service provided?

- 33 local juvenile courts in Washington refer youth to the Juvenile Rehabilitation Administration under the "determinate sentencing system" (created by state legislature) which also applies to adults (combining seriousness of offense and history of offenses for length of time served, often 30 days).
- JRA Division of Institutions Programs operates three institutions, one work camp and one basic training camp. The institutions are located in Snoqualmie, Centralia, and Chehalis. The work camp is located in Naselle and the Basic Training Camp is in Connell, WA. Each of these facilities serves as the origin of services for adolescent offenders. They receive cognitive behavioral treatment interventions, which include vocational, educational and behavioral interventions by trained staff members.
- As youth progress and improve in treatment, they move to a less restrictive community facility, usually for 4-5 months. These sites are structured while allowing youth to continue in treatment, go to high school, and have jobs.
- JRA Division of Community Programs currently operates seven State operated Community Facilities, three contracted Community Facilities and specialized foster care. Locations include Olympia, Lakewood, Woodinville, Renton, Tacoma, Ellensburg, Richland, Wenatchee, Spokane, Yakima, and Ephrata.
- Youth are required to pay up to 50 percent of restitution damage through community service, to understand the harm that they have created.
- Once sentencing requirements are complete, one of three things occurs: aged out, living with families on parole, and living with families off of parole. On parole, JRA parole case managers work with family and youth to improve communication, expectations, and assist in substance abuse programs, sex offender treatment, family therapy, and mentoring.
- Beginning in 2002, the "Integrated Treatment Model" was implemented. One of the components is after-parole activities focusing on the whole family instead of primarily on the adolescent offender [Functional Family Parole (FFP)].[1]

[1] Juvenile Rehabilitation Administration, "Integrated Treatment Model", Website: http://www1.dshs.wa.gov/pdf/JRA/ITM_Design_Report.pdf]. Accessed 4/20/05.

Eligibility

- Court appoints any juvenile 8-21 years old according to the Sentencing Guidelines of state legislature.[2]

Who is receiving the service?

Characteristics of Residential Population, March 31, 2005[3]

Gender	***Number***	***Percent***
Male	778	91.1%
Female	76	8.9%

Age	***Number***	***Percent***
< 15	91	10.7%
15-17	584	68.4%
18-20	179	21.0%

Common Issues Encountered in Residential Care (Last updated January 2005)

Description	***Involved in Residential Care (%)***
Significant mental health issues	64%
Chemically dependent	81%
Cognitively impaired	40%
Sexual misconduct issues	30%
Two or more of the above	60%

Issues/concerns [4]

- WA State Institute for Public Policy conducted a study demonstrating that evidence-based rehabilitation and therapeutic interventions significantly dropped crime recidivism compared to the former Corrections Model. [5]
- Increasing pressure on residential and community counselors to serve multiple needs.
- Conflicting demands between incarceration and rehabilitation

[2] State of Washington Sentencing Guidelines Commission "Juvenile Disposition Manual 2004", Website: http://www.sgc.wa.gov/PUBS/Juvenile/Juvenile_Disposition_Manual_2004.pdf Accessed 5/25/05
[3] Juvenile Rehabilitation Administration, "Population Summary Report, January – March 2005". Published April 12, 2005.
[4] Juvenile Rehabilitation Administration, http://www1.dshs.wa.gov/jra/
[5] Washington State Institute for Public Policy, "Recommended Quality Control Standards: Washington State Research-Based Juvenile Offender Programs". December 2003. Website: http://www.wsipp.wa.gov/

Mental Health Services

What is the service?

- The Mental Health Division (MHD) of the Washington State Department of Social and Health Services is the state agency responsible for providing publicly funded mental health services. Services in Washington State are administered through 14 Regional Support Networks (RSN), they include:
  - Mental Health Crisis Services
  - Outpatient Mental Health Services
  - Inpatient Mental Health Services: Community Hospitals, Freestanding Evaluation and Treatment Centers, Adult State Hospitals and Children's Long-term Inpatient Programs
  - Involuntary Treatment Services
- The MHD collaborates with state and local government, private and public agencies, as well as Tribes and other Department of Social and Health Services divisions (DSHS) to ensure that the needs of women and children with mental illness are met.
- MHD's website can be viewed at: http://www1.dshs.wa.gov/mentalhealth/index.shtml.

How/where provided?

Mental Health Crisis Services

Description
- Crisis intervention and emergency assistance in person and via the phone for mental health crises

Eligibility
- No limit on eligibility to call—available to all state residents

Served
- 39 crisis lines are operated, one for each county
- Information on number of calls made using the crisis line is not available (calls are logged differently in each county).
- Other crisis services provided by mobile crisis teams, crisis diversion beds, etc. Crisis services such as these also vary from county to county in terms of documentation, making aggregate numbers of accessed crisis services unavailable.

Outpatient Mental Health Services

Description
Services include: day support, family treatment, group treatment services, high intensity treatment, individual treatment services, intake evaluation, medication management, medication monitoring, peer support, psychological assessment, rehabilitation case management, special population evaluation, stabilization services, and therapeutic psychoeducation.

Eligibility
- Adults ≥19 who are Medicaid recipients are eligible to be assessed for mental health services
- Children <19 who are Medicaid recipients are eligible to be assessed for mental health services
- The RSN must determine that a person meets the medical necessity criteria, access to care standards, or has a mental disorder requiring treatment in order to access services.

Served
- 126,867 people in Washington State used mental health services in 2003 [2]
- 37,547 were children ages 0-17 [1,2]

Inpatient Mental Health Services

Description
- Community Hospitalization
- Free standing Evaluation and Treatment Facilities (E&Ts)

Eligibility
- Adults ≥18 who are Medicaid recipients who are evaluated by the RSN as needing hospital care due to a mental health crisis.
- State funding is available for inpatient services for some persons not eligible for Medicaid.

Served
- 8,444 people in Washington State were hospitalized in community hospitals and free standing E&Ts for mental health conditions in 2003[2]
- 939 were children ages 0-17 [1,2]

Children's Long-term Inpatient Program (CLIP)

Description
- Long-term residential treatment for children experiencing severe psychiatric conditions and in need of inpatient care.

[1] Majority of children utilizing public mental health services are between the ages of 10 to 17
[2] Washington State Department of Social and Health Services, Mental Health Division, "State-Wide Publicly Funded Mental Health Performance Indicators". December 2004

Eligibility
- Any child up to the age of 17 with a severe psychiatric illness whose needs cannot be met in the community.
- Medicaid medical necessity criteria must be met.
- All children admitted to CLIP are eligible for Medicaid during their treatment stay.

Served
- 91 beds statewide [3]
- 4 sites: Tamarack (Eastern Washington), Pearl Street Center, McGraw Child Study and Treatment Center (Western Washington) [3]
- 212 children were served in July 1 - June 30, 2003[1,3]
- 2002 CLIP report indicated 41% of children waited between 30 and 60 days before admission, and 39% waited less than 30 days.[3]

Adult State Hospitals

Description
- Long-term residential treatment for adults experiencing severe psychiatric conditions and in need of inpatient care.
- Residential treatment is provided at both Eastern State Hospital and Western State Hospital.
- Services provided by Western State Hospital: Center for Adult Services (adults ages 18 to 59), Center for Geriatric Services (adults 60 years of age and older), Center for Forensic Services (alleged and convicted criminals), Program for Adaptive Living Skills (transition to community), Rehabilitative Services (recreational, speech, and audiology therapy), Support Services, and Mental Health Ombudsman.
- Services provided by Eastern State Hospital: Adult Psychiatric Unit (adults ages 18 to 59), Center for Geropsychiatric Services (adults ages 50 and over), and the Forensic Services Unit (alleged and convicted criminals.)

Eligibility
- Medicaid recipients <=185% FPL
- Any adult committed through the judicial system under RCW 10.77 or civilly committed through RCW 71.05, commitment is based upon the presence of grave disability from mental illness. The process must be initiated by a County Designated Mental Health Provider (CDMHP.)
- Voluntary admissions can be done only at Western State Hospital.

Served
- Eastern State Hospital Total Beds: 274 [4]
- Western State Hospital Total Beds: 883 [4]
- Admissions to Eastern State Hospital from July 1, 2003 – June 30, 2004: 940 [4]
- Admissions to Western State Hospital from July 1, 2003 – June 30, 2004: 1,506 [4]

[3] Washington State Department of Social and Health Services, CLIP Administration, "CLIP Summary Report 1991-2002". December 2003
[4] Washington State Department of Social and Health Services, Mental Health Division, "Capacity and Demand study for Inpatient Psychiatric Hospital and Community Residential Beds – Adults and Children". November, 2004

Involuntary Treatment Services

Description
- Involuntary treatment orders for people experiencing severe mental illness that may result in the harming of themselves or others.
- Involuntary treatment is done through the courts and must be ordered based on the recommendations of a CDMHP.
- Involuntary treatment may occur on an outpatient or inpatient basis.

Eligibility
- Available for children between the ages of 13 to 17, and adults 18 and older.
- Must be determined by a CDMHP to present a likelihood of serious harm to self or others, or is gravely disabled.
- Used when voluntary inpatient services are not possible (refusal of patient to go voluntarily)
- Some state funding is available for those not eligible for Medicaid, or for those without private insurance or other means to pay.

Served
- 2,404 people in Washington State were involuntary committed to an inpatient facility for treatment in 2003 [4]
- Of the 212 children admitted for inpatient mental health treatment in 2003 [2], 96 children were involuntarily admitted to CLIP facilities.[1,3]

Who is receiving the service?

Percent of Patients Receiving Publicly Funded [5]Outpatient Mental Health Services [6], Youth (0 – 17 yrs)[1], Fiscal Year July 2002 – June 2003 [2]

RSN	Number of Patients Served	Population (0-17)	Percent Served
Northeast	572	19,106	3.0%
Grays Harbor	811	17,251	4.7%
Timberlands	967	23,601	4.1%
Southwest	1,224	24,905	4.9%
Chelan/Douglas	846	28,238	3.0%
North Central	883	40,943	2.2%
Thurston/Mason	1,427	64,146	2.2%
Clark	2,403	98,985	2.4%
Peninsula	1,729	81,372	2.1%
Spokane	2,922	107,500	2.7%
Greater Columbia	5,341	172,625	3.1%
Pierce	4,408	190,569	2.3%

[5] Includes services funded by both Medicaid and Washington State dollars
[6] Unduplicated number of Medicaid enrollees accessing Medicaid mental health services.

North Sound	6,064	254,406	2.4%
King	8,462	390,646	2.2%
Statewide	37,547	640,716	2.5%

Percent of Patients Receiving Publicly Funded [5] Outpatient Mental Health Services [6], Adults (18-59 years), July 2002 – June 2003 [2]

RSN	Number of Patients Served	Population (18-59)	Percent Served
Northeast	1,284	36,728	3.5%
Grays Harbor	1,285	36,493	3.5%
Timberlands	2,489	48,759	5.1%
Southwest	3,175	51,765	6.1%
Chelan/Douglas	1,670	53,716	3.1%
North Central	1,670	69,238	2.4%
Thurston/Mason	3,042	150,573	2.0%
Clark	4,012	201,831	2.0%
Peninsula	4,315	183,899	2.3%
Spokane	5,701	243,787	2.3%
Greater Columbia	10,011	337,983	3.0%
Pierce	9,246	414,860	2.2%
North Sound	10,991	570,893	1.9%
King	19,432	1,106,531	1.8%
Statewide	76,339	3,507,056	2.2%

DSHS Mental Health Service Use Totals [7,8], July 2002 – June 2003 [3,9]

	Adults (18-59)		Youth (0-17) [1]	
Service	Number Served	Use Rate	Number Served	Use Rate
Children's Long-term Inpatient Program	1	-	212	-
Community Inpatient Evaluation and Treatment	6,671	0.2%	944	0.1%
Community Services (Outpatient)	78,883	2.0 %	37,071	2.4%
Adult State Hospitals (Institutions)	2,983	0.1%	4	-

Issues/Concerns

- Mental health funding has not kept up with population pressure and the increased cost of delivering public mental health services.

[7] Duplicated number of services accessed by Medicaid enrollees
[8] Rates are calculated based on population totals for age-specific groups in Washington State
[9] Washington State Department of Social and Health Services. "DSHS Services and Clients – 2003" Website Accessed: http://www1.dshs.wa.gov/rda/research/clientdata/2003/default.shtm . Website accessed July 1, 2005

Nutrition Services

Publicly funded nutrition services in Washington include the Washington Basic Food Program (BFP), the Basic Food Nutrition Education Program (BFNEP), the Supplemental Nutrition Program for Women, Infant, and Children (WIC), Maternity Support Services, Emergency Food Assistance Program (EFAP), and the School Lunch Program.

Washington Basic Food Program (BFP)

What is the service?

The Washington Basic Food Program (BFP) aims to allow financially needy families access to a more nutritious diet by increasing their ability to afford food. BFP supplements the incomes of families by providing food assistance. BFP is administered by the Washington State Department of Social and Health Services. Benefits are made possible through the United States Department of Agriculture Food and Nutrition Services' federal food stamp program and the Washington State General Fund. http://www1.dshs.wa.gov/esa/eazmanual/Sections/PS_FedFoodAssist.htm https://wws2.wa.gov/dshs/onlinecso/food_assistance_program.asp

Basic Food Program clients may be required to register for work and participate in the Food Stamp Employment and Training program as a condition of eligibility for benefits. The program provides job search, education and training services to help Basic Food recipients find employment and achieve self sufficiency. At this time the Food Stamp Employment and Training program is only available in King County.
http://www1.dshs.wa.gov/esa/eazmanual/Sections/FSETgenrqmnts.htm

How/where is it provided?

Basic Food Program has two programs: [1]

- The Federal Food Stamp Program (FSP) provides benefits paid directly to eligible clients through Electronic Benefits Transfer (EBT) cards, which can be used at all participating grocery stores. The household net income and family size determine the amount on the EBT card.
- The Food Assistance Program for Legal Immigrants (FAP) is state funded and serves legal immigrants who are ineligible for the FSP due to citizenship status. Benefit payments are similar to FSP.

Eligibility

Household gross income less than or equal to 130% of the Federal Poverty Level (FPL). [1] Household net income (after allowable deductions) less than or equal to 100% FPL. Additional eligibility requirements for individuals can be found at:
http://www1.dshs.wa.gov/esa/eazmanual/Sections/PS_FedFoodAssist.htm
https://wws2.wa.gov/dshs/onlinecso/food_assistance_program.asp

[1] Washington State Department of Health, Basic Food Program." Website: https://wwws2.wa.gov/dshs/onlinecso/food_assistance_program.asp

Who is receiving the service?

The following information and table come directly from the Economic Services Administration (ESA) Briefing Book and highlight the demographic characteristics of clients served. [2]

- Approximately 525,000 clients received food stamp benefits in State Fiscal Year (SFY) 2005.
- Children made up 42.5% of the recipients.
- Over 14% of the state's child population received food stamp benefits in SFY 2005.
- The average payment per case in SFY 2005 was $174 (on average there were 2 people per case).

Basic Food Program Client Demographics, June 2005
Source: ESA-ACES Data

Characteristic	All Clients		All Adults		All Children	
	(525,451)	Percent	(305,144)	Percent	(220,307)	Percent
Gender						
Female	292,305	55.6%	183,454	60.1%	108,851	49.4%
Male	233,119	44.4%	121,674	39.9%	111,445	50.6%
Unknown	27	0.0%	16	0.0%	11	0.0%
Race						
White	318,909	60.7%	204,435	67.0%	114,474	52.0%
Hispanic	75,212	14.3%	27,496	9.0%	47,716	21.7%
Black	45,492	8.7%	25,944	8.5%	19,548	8.9%
Asian/Pacific Islander	24,171	4.6%	16,549	5.4%	7,622	3.5%
Native American	18,946	3.6%	11,836	3.9%	7,110	3.2%
Unknown	42,721	8.1%	18,884	6.2%	23,837	10.8%
Age						
<17 years	212,431	40.4%	0	0.0%	212,431	96.4%
17-20 years	29,430	5.6%	21,554	7.1%	7,876	3.6%
21-49 years	200,269	38.1%	200,269	65.6%	0	
50-64 years	52,394	10.0%	52,394	17.2%	0	
65+ years	30,927	5.9%	30,927	10.1%	0	0.0%

Basic Food Nutrition Education Program (BFNEP)

What is the service?

[2] Washington State Department of Social and Health Services. "ESA Program Briefing Book." Website: http://www1.dshs.wa.gov/pdf/esa/briefbook/2005program_descriptions.pdf June 2005.

The Basic Food Nutrition Education Program (BFNEP) educates those participating or eligible for the Basic Food Program on ways to eat healthy and be active. It is a partnership between the Washington State Department of Health, United States Department of Health and Human Services, and the USDA. BFNEP benefits are provided through the USDA Food and Nutrition Services, sponsored by the Department of Health, and composed of contracted government partnerships with local health jurisdictions, Tribal Organizations, as well as non-profit organizations. Activities are targeted to Basic Food Program participants. http://www.doh.wa.gov/cfh/bfnep/default.htm

How/where is it provided?

BFNEP services are provided by the contracted agency, including 12 Local Health Jurisdictions (LHJs), 11 Indian Tribal Organizations, one state agency (serving 18 local sites), and one non-profit organization.[3]

Eligibility

BFNEP contractors must demonstrate targeted activities for individuals and families participating or eligible for the Basic Food Program.[1] A federal waiver allows contractors to provide interventions to groups where at least 50% of the audience is at or below 185% FPL. Additional requirements can be found at: http://www.doh.wa.gov/cfh/bfnep/publications/BFNEP_Guidance_FFY06.pdf

Who is receiving the service?

Information from the Federal Fiscal Year (FFY) 2005 Annual Report indicates that 346,757 individuals received nutrition education services (107,115 directly and 239,642 indirectly).[1] A listing of contractors and contact information can be found at: http://www.doh.wa.gov/cfh/bfnep/publications/BFNEP_Guidance_FFY06.pdf

Supplemental Nutrition Program for Women, Infants, and Children (WIC)

What is the service?

WIC provides healthy foods, nutrition and physical activity education, breastfeeding support, health screening, and referrals to health and social services to low-income pregnant women, new mothers, infants and children under the age of five. WIC is funded by the U.S. Department of Agriculture and is operated by the Washington State Department of Health (http://www.doh.wa.gov/cfh/WIC/default.htm).

- Women (pregnant, breastfeeding and postpartum) and children receive checks to buy milk, eggs, cheese, sugar free juice, peanut butter, low-sugar, high iron cereal, and dried beans, peas and lentils. During summer months, clients can receive produce from authorized farmers markets (http://nutrition.wsu.edu/markets/index.html). Infants receive

[3] Washington State Department of Health, "Basic Foods and Nutrition Education Program". Website: http://www.doh.wa.gov/cfh/bfnep/default.htm . Accessed 11/05

checks for high vitamin C juice and iron fortified infant cereal. For infants not breastfed, WIC provides checks for iron fortified infant formula.

- Health screening includes client interviews, weighing and measuring, checking blood iron levels, assessing diet and eating patterns, and screening for immunization status.

How/where is it provided? [4]

WIC is provided throughout the state at migrant and tribal health centers, health departments, social service centers, hospitals, military bases, community centers, and churches. In Washington there are 225 WIC sites operated by 66 WIC agencies.

Eligibility [4]

Participants must be a pregnant, breastfeeding or postpartum woman, with an infant or a child under age 5with a household income at or below 185% of the Federal Poverty Level. Women and children enrolled in Medicaid are adjunctively income eligible for WIC. In addition, clients must have an identified nutrition, dietary, or health need in order to be eligible for WIC.

WIC is not an entitlement program. Determination of who will be served is based on a federal priority system. Pregnant women, breastfeeding women, and infants are top priority for service. Children age 1 to 5 are served next. Additionally, if funding allows, non-breastfeeding mothers are served until 6 months postpartum.

Additional requirements can be found at: http://www.doh.wa.gov/cfh/WIC/eligibility.htm

Who is receiving the service?

- In FFY 2005, over 50% of all infants born in Washington were served by WIC. In rural counties over 66% of all infants born were served. Approximately 270,000 women and children are served each year.

Race/Ethnicity Distribution of WIC Clients, April 2005 [4]
(Unduplicated and adjusted for King County)

Race/Ethnicity	Unduplicated Clients	Percent of WIC Clients
American Indian	8,404	4.9%
Asian or Pacific Islander	11,483	6.7%
Black	14,235	8.3%
Hispanic	55,791	32.5%
White	81,587	47.6%
Totals	171,500	100.0%

[4] Washington State Department of Health, "Women, Infant, and Child (WIC) Program". Website: http://www.doh.wa.gov/cfh/WIC/default.htm. Accessed 11/05

Income of WIC Clients as Percent of Poverty, April 2005

Percent of 2005 Federal Poverty Level	Percent of WIC Clients
No income	7.8%
1-85%	47.3%
86-105 %	12.2%
106-125%	10.6%
126-135%	4.4%
135-165%	10.6%
166-185%	4.0%
Over 185% (enrolled in Medicaid)	3.1%
Total	100%

Maternity Support Services (MSS)

What is the service?

Maternity Support Services (MSS) is a component of First Steps services provided to low income pregnant women. MSS include preventive health services by a multidisciplinary team including a Registered Dietitian (RD). The RD's role is to provide nutrition consultation to the other MSS team members in addition to screening, assessing, educating, counseling, and providing referrals to eligible clients. Currently, 60% of MSS dietitians also provide nutrition services for the Women, Infant and Children (WIC) Supplemental Nutrition Program. (See the *First Steps* services section for additional information). In 2003, 25,521 women on Medicaid received First Steps services. Approximately 14% of the First Steps services provided were nutrition services.[5,6]

Emergency Food Assistance Program (EFAP)

What is the service?

EFAP provides support to community and tribal programs that deliver emergency food assistance. It is a program of the Washington State Department of Community, Trade, and Economic Development. Assistance comes from the Washington State General Fund and includes funding support for food banks, tribes, food purchases, and training for food bank staff. http://cted.wa.gov/portal/alias__cted/lang__en/tabID__271/DesktopDefault.aspx

How/where is it provided?

Food banks, distribution centers, and tribes can apply for funding support and technical assistance every two years.

[5]Cawthon, L. Maternity Support Services and Maternity Infant Case Management Use by Women with Medicaid-paid Births in 2003, Washington State Department of Social and Health Services First Steps Database, 4/18/05.
[6]Conlon, D. Medical Assistance Administration First Steps Procedures by Procedure Code and Date of Service, Fiscal Years 2003-2005 Dates of Service. Washington State Department of Social and Health Services, 7/29/2005.

Eligibility [1]

- Food Banks are eligible for assistance if they've been operational for at least one year, meet matching requirements, and do not charge a fee for services. Additional requirements can be found at:

http://cted.wa.gov/portal/alias__cted/lang__en/tabID__277/DesktopDefault.aspx

- Tribes are eligible for assistance if they are federally recognized or are a non-profit organization, meet match requirements, and do not charge for services. Additional requirements can be found at:

http://cted.wa.gov/portal/alias__cted/lang__en/tabID__277/DesktopDefault.aspx

Who is receiving the service?

A listing of contractors and contact information can be found at:
http://cted.wa.gov/portal/alias__cted/lang__en/tabID__277/DesktopDefault.aspx

School Lunch Program Services

What is the service?

- The National School Lunch Program is a federally-assisted meal program, offering low-cost/free nutritious meals to students in school. As of 1998, snack reimbursement during after-school programs is also included. The program also provides nutritious meals to students in public, private, and residential child care institutions (RCCIs).
- Websites:
  - www.k12.wa.us/ChildNutrition/
  - http://www.fns.usda.gov/cnd/lunch/default.htm

How/ where is the service provided?

- Washington has 382 Local Education Agencies (LEA's) providing free and reduced meals at: [7]
  - 278 public school districts
  - 46 private schools
  - 58 residential schools
- Various state education agencies operate with LEAs
- During the 2004-05 school year, participating schools received the following cash subsidies (free lunches: $2.24; reduced price: $1.84; paid lunches: $0.21; free snacks: $0.61; reduced-price snacks: $0.30; paid snacks: $0.05) from the US Department of Agriculture for every meal served that met the federal nutritional requirements. Schools also receive donated goods ("entitlement" foods: $17.25/each meal served and extra commodities) from surplus agricultural stocks. Additionally, LEAs can receive reimbursement for after-school snacks served to children up to the age of 18 years that participate in educational or enrichment programs.

[7] Office of Superintendent of Public Instruction, "A Partnership education: Child Nutrition Programs Washington State 2005".

- Nutritional requirements: <10 percent of calories from saturated fat, ≤ 30%of calories from fat overall, and one-third of "Recommended Dietary Allowances" of calories, protein, Vitamins A and C, iron, and calcium.
- As long as federal requirements are satisfied, the particulars can be determined by each school.

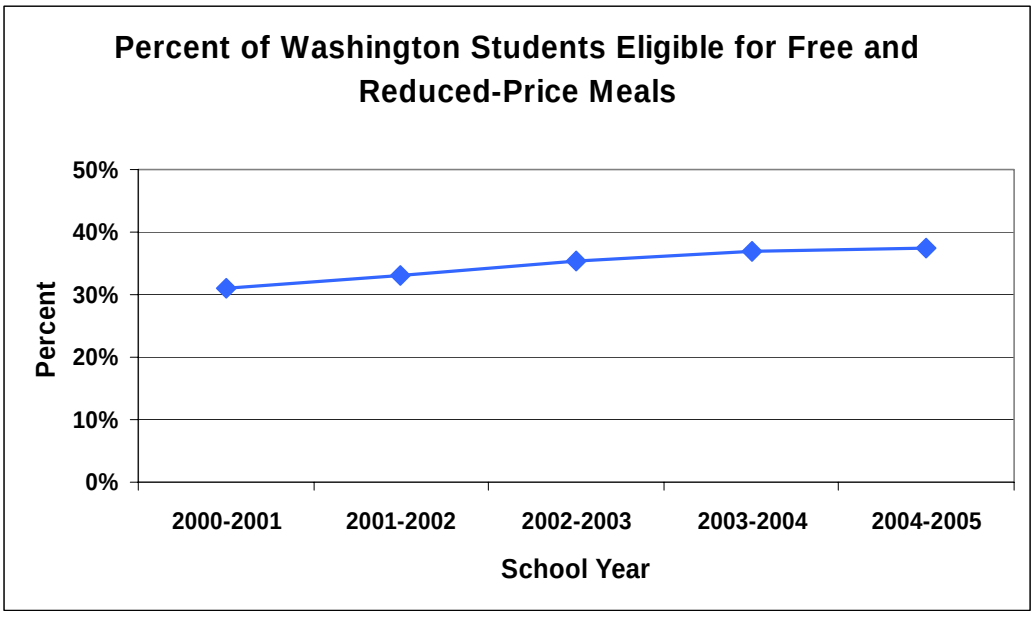
Eligibility [8]

- Students in households at or below 130% FPL (Federal Poverty Level) can receive free meals.
- Students in households from 130% - 185% FPL can receive reduced-price meals (charged no more than $0.40/each).
- Students in households > 185% FPL receive full price meals which can be subsidized.
- Same eligibility requirements hold for snacks unless ≥ 50% of children in the program are eligible, then all snacks are free.

Who is receiving service?

Public School Free/Reduced-Price Lunch, School Year 2004-2005 [2, 9]

Year	*Total K-12 School Enrollment*	*# Free/Reduced Lunch Applications*	*% Eligible for Free/Reduced Lunch*
2004-2005	1,000,780	375,427	37.5%



[8] USDA, Nutrition Program Facts, Food and Nutrition Service, "National School Lunch Program", Website accessed: http://www.fns.usda.gov/cnd/Lunch/default.htm Accessed 8/05

[9] Office of Superintendent of Public Instruction, Child Nutrition Services, "*Child Nutrition Programs Washington State 2005*".

National School Lunch Program, Public Schools Only, School Year 2004-2005 [2, 4]

Districts on National School Lunch Program	278
Districts not on National School Lunch Program	18
School/sites on National School Lunch Program	1,927
School/sites not on National School Lunch Program	19
Average Daily Participation, October 2004	478,940
Children with Access to Lunch	1,000,142
Children without Access to Lunch	10,646
TOTAL	1,010,788

Nutrition Services Issues/Concerns

- While food security has improved in Washington over the past few years, on average from 2002-2004, 12% of Washingtonians were food insecure and about 4% were food insecure with hunger.[10]
- In 2003, about 60% of the estimated eligible population in Washington received food stamp benefits. The USDA performance target for 2010 is 68%.[11]
- WIC also helps address food insecurity and hunger among pregnant women and young children, but it is not an entitlement program and limited funding prohibits WIC from serving all eligible clients. Unpredictable increases in food costs also impact WIC's ability to meet client need.
- In many areas of Washington, WIC agencies are not able to serve postpartum women due to funding limitations. This is unfortunate since research indicates that future births are healthier when mothers are served until 6 months post-partum.
- Increasingly limited local government and community funding has begun to impact the ability of local WIC providers to meet community needs and has influenced the reach of the Basic Food and Nutrition Education Program.
- Promoting nutrition and health among food support programs remains challenging on many fronts.
    - The Basic Food Nutrition Education Program promotes connections between food availability, nutrition and physical activity. Yet, current USDA guidelines limit both the amount of time that the Basic Food Nutrition and Education Program can devote to promoting physical activity and to policy and environmental change activities related to nutrition and physical activity.
    - Enforcement of nutritional standards for the school lunch program have emphasized reducing the amount of dairy and hi-fat proteins in recent years.[12]

[10] Household Food Security in the United States, 2004.
[11] Castner LA, Shirm AL. Reaching those in Need: State Food Stamp Participation Rates in 2003. United States Department of Agriculture, Food and Nutrition Services, November 2005. http://www.fns.usda.gov/oane/menu/Published/FSP/FILES/Participation/reaching2003.pdf
[12] CNN "Officials, experts grapple with school lunch programs". Posted December 11, 2003. Website: http://www.cnn.com/2003/EDUCATION/12/11/school.lunch.ap/. Accessed 4/15/05

Oral Health Services

What are the services?

Several publicly funded programs and services throughout the state aim to increase access to preventive and treatment activities. A brief overview of them is provided below.

Oral Health Education, Promotion, and Prevention Programs

- WA State Oral Health Program Website. The WA State Oral Health Program maintains a website with educational and evidence-based information on oral health issues. The program promotes the use of Bright Futures oral health messages, in conjunction with other general health messages, to pregnant women, children and adolescents. Website: http://www.doh.wa.gov/cfh/mch/cahcp/oral_health.htm
- University of Washington (UW) Oral Health Collaborative. The UW Oral Health Collaborative is an outreach component of the Dental Hygiene Program that creates and delivers models for oral health education and prevention. The models involve local partners and can be replicated and sustained at the community level to improve the oral health of underserved children.
- UW School of Dentistry Pipeline, Practice, and Profession: Community–Based Dental Education. The UW School of Dentistry conducts a project to increase access to dental care for underserved populations by increasing recruitment and retention of disadvantaged and underrepresented minority students into dentistry.
- UW Community-Based Clinical Training. The UW School of Dentistry provides an opportunity for UW 4th year dental students to provide care in more than 15 community-based clinics statewide, including Seattle, Yakima Valley, Southwest Washington and Bellingham.

Oral Health Services

- State Oral Health Program and Local Health Jurisdictions. The State MCH Oral Health Program contracts with 35 Local Health Jurisdictions (LHJs) to provide preventive dental services that include: oral health education, school-based sealants, screening for oral health needs and treatment, referrals to insurance programs and to local dental providers for services, etc. DOH website with access to LHJs under construction.
- Community and Migrant Health Centers (CMHCs). CMHCs provide health care services to uninsured, underinsured and low income clients with Medicaid or the Basic Health Plan. There are 25 CMHCs, (including 5 look-alikes) with a total of 135 sites, 58 of which offer dental services. There are also 21 free clinics, 3 of which provide dental services. (See *Safety Net Services* chapter for additional information). http://www.wacmhc.org/
- Tribal Health Clinics: Out of the 29 federally recognized tribes, there are 23 Tribal Health Clinics that provide dental services in Washington State. (See *Safety Net Services* chapter for additional information).
- Clinics at Dental Professional Training Programs. Dental clinics typically serving low income clients are operated by the University of Washington, eight Dental Hygiene and 8 Dental Assisting schools in Washington.

- UW Dental Education in the Care of Persons with Disabilities (DECOD). DECOD treats persons with severe disabilities and prepares dental professionals to meet their special oral health needs. DECOD also includes a mobile dental van for residents of long-term care facilities and the homebound. http://www.dental.washington.edu/departments/oralmed/decod/
- Mobile Dental Vans. Mobile Dental Vans provide dental care to community residents in areas which do not have access to care. Some vans are operated by: the Northwest Medical Teams (3 vans), Yakima Valley Farm Workers Clinic, Olympic Community Action Program, DECOD, and the Free Clinic of SW Washington's Mobile Clinic.
- Volunteer groups. Many community professionals and organizations (charitable, religious, etc.) provide dental services on a voluntary basis for the underserved, often in connection with local dental professional societies.
- Medicaid. Under Health Services Recovery Administration, Medical Assistance pays for covered dental and dental-related services for children and adults. Children's services include the Access to Baby and Child Dentistry Program (ABCD) http://fortress.wa.gov/dshs/maa/ProvRel/Dental/Dental.html
- Kids Get Care. Operated by Seattle-King County, Kids Get Care promotes early integrated preventive physical, oral and developmental health services to children regardless of insurance status through attachment to a dental home. http://www.metrokc.gov/health/kgc/
- Sea-Tac Smiles. The King County Health Action Plan developed this project to test a model for increasing low-income residents' access to dental services by building capacity at dental assisting schools and providing community-based dental training for students through a full-time clinic. http://www.metrokc.gov/health/kgc/smiles.htm

How/where are the services provided?

- These programs and services provide either preventive or treatment opportunities in diverse settings throughout the state.

Eligibility

- Most of these services focus primarily on low-income MCH groups.

Issues/concerns

- Washington children suffer more tooth decay than the rest of the nation, a problem that is exacerbated by the lower rate of fluoridated public water systems in the state.
- Additional partnerships among providers, public health and communities are needed to help improve the oral health status of Washingtonians.

Safety Net Services

What is the service?

- The Institute of Medicine defines safety net providers as "those providers that organize and deliver a significant level of health care and other health-related services to uninsured, Medicaid, and other vulnerable patients."[1] In Washington State, safety net providers offer primary care, dental, and mental health services. While there is some variation, clinics primarily serve clients enrolled in Medicaid, Medicare, or Basic Health, or who are uninsured.
- Safety net providers include Community and Migrant Health Centers, Free or Charity Care Clinics, Public Health Clinics, Rural Health Clinics, residency programs, public hospitals, and tribal clinics.[2]
- 2002-2003 estimates of Washington State's primary care physician safety net capacity[3] indicate that out of approximately 1,800 FTEs (excluding King and Pierce counties, as data are not yet available)
    - 71% of private practice physician capacity is not in a safety net role
    - 9% of physician capacity is in Community and Migrant Health Centers
    - 16% of physician capacity is in Rural Health Clinics
    - 2% of physician capacity are in tribal clinics and 2% are in residency programs
    - Physician capacity by clinic type varies considerably by urban and rural counties. Rural counties tend to have a lower percentage (42%) of private practice, and a higher percentage (44%) of physician capacity in Rural Health Clinics. See *Washington's Primary Care Safety Net: Structure and Availability* for more information.

How/where is the service provided?

Community and Migrant Health Centers (CMHCs)

- Many CMHCs receive federal funding and are referred to as Federally Qualified Health Centers (FQHCs)
- Many CMHCs also receive state funding through the Community Health Services Program, based out of the Washington State Health Care Authority
- CMHCs focus on providing services to those who are underinsured or have Medicaid or Basic Health
- CMHCs are second only to the emergency room in providing care to the uninsured in most communities
- There are approximately 100 clinic sites in Washington, 80 with dental care, and 30 with mental health/wellness services

[1] Institute of Medicine, *America's Health Care Safety Net: Intact but Endangered*. 2000. http://www.nap.edu/books/030906497X/html/21.html
[2] Schueler, V *Washington's Primary Care Safety Net: Structure and Availability*. Office of Community and Rural Health, Washington State Department of Health. http://www.doh.wa.gov/hsqa/ocrh/har/Wapcnet.doc
[3] Schueler, V *Washington's Primary Care Safety Net: Structure and Availability*. Office of Community and Rural Health, Washington State Department of Health. http://www.doh.wa.gov/hsqa/ocrh/har/Wapcnet.doc. Physician capacity is defined as the total FTE (1 FTE = 40 hours a week of direct patient care).

Free or Charity Care Clinics

- Operated by community service organizations or churches, with donated labor and materials
- Some clinics receive state funding through the Community Health Services Program
- Approximately 20 free or charity clinics in Washington

Public Health Clinics

- Public Health Seattle-King County has four primary medical care and five dental clinics, which primarily provide preventive care and care for the homeless
- Most of Washington's local health jurisdictions do not provide direct medical care

Rural Health Clinics (RHCs)

- Located outside urbanized areas in Health Professional Shortage Areas
- Clinics receive enhanced reimbursement for Medicaid and Medicare patients
- As of March 2004, there were 106 Federally Certified Rural Health Clinics in Washington State
- The number of RHCs has steadily increased over the past three years. This increase is expected to continue over the next 3-5 years.
- Most clinics limit sliding fee and charity care to less than 5% of total patients seen

Primary Care Residency Programs

- Located in Bremerton, Olympia, Seattle, Spokane, Tacoma, Vancouver, Yakima, Colville and Goldendale.
- Programs provide training to resident physicians as part of their post-graduate education
- The program has not grown, and may contract over time. This may be due to the decreasing percentage of medical students entering primary care, the increased malpractice insurance costs, and difficulty matching residents with open residency slots.

Tribal Health Clinics

- Of the 29 federally recognized tribes in Washington State, 23 operate tribal health clinics
- Four of these clinics are operated by the Indian Health Service and are open only to tribal members
- The remaining clinics (operating under federal Indian Self-Determination and Education Act) increasingly rely on Medicare, Medicaid, other third-party revenue sources, and revenue from tribal enterprises.[4] Some of these clinics are open to non-members.

Eligibility

Safety Net clinics primarily serve clients enrolled in Medicaid, Medicare, or Basic Health, or who are uninsured.

[4] Schueler, V *Washington's Primary Care Safety Net: Structure and Availability.* Office of Community and Rural Health, Washington State Department of Health. http://www.doh.wa.gov/hsqa/ocrh/har/Wapcnet.doc.

Who is receiving the Service?

Community and Migrant Health Centers (CMHCs), that are Federally Qualified Health Centers (FQHCs) [5]***:***

Number of Visits and Clients at FQHCs in Washington State, 2003:

	# visits	# clients
Medical Service	1,409,514	396,994
Dental Service	389,026	156,468
Mental Health Services	21,923	8,174
Total	**1,820,463**	**561,636**

Number of Pregnant Clients at FQHCs in Washington State, 2003: **12,591**

Age and Sex of Clients at FQHCs in Washington State, 2003:

Age	Female	Male	Total Number Served
0-4	49.6%	50.4%	60,172
5-14	50.3%	49.7%	92,850
15-17	57.2%	42.8%	23,402
18-19	64.7%	35.3%	15,851
20-44	61.4%	38.6%	208,574
45-64	58.3%	41.7%	83,780
65+	60.6%	39.4%	22,064
Total	**57.3%**	**42.7%**	**506,693**

Race and Ethnicity of Clients at FQHCs in Washington State, 2003:

Race/Ethnicity	Number	Percent
Hispanic	188,481	37.2%
White	221,744	43.8%
Black	27,997	5.5%
Native American or Alaska Native	8,470	1.7%
Asian or Pacific Islander	32,731	6.5%
unreported	27,270	5.4%
Total	**506,693**	**100.0%**

[5] Data provided by the Washington Association of Community and Migrant Health Centers. Data provided include 19 of the 23 FQHC grantees in Washington. The total number of clients may have clients counted more than once, since a single patient may receive medical, dental or mental health services. Utilization counts may also include duplicates.

Payment Type of Clients at FQHCs in Washington State, 2003:

Payment Type	Number	Percent
Sliding Scale/uninsured	183,403	36.2%
Medicaid	194,462	38.4%
Basic Health	46,332	9.1%
Medicare	21,599	4.3%
Private Insurance	60,897	12.0%
Total	**506,693**	**100.0%**

Community Health Services

- Data on clinics that receive Community Health Services Program funding are available at http://www.hca.wa.gov/chs/doc/ar2004.pdf through the Washington State Health Care Authority (http://www.chs.hca.wa.gov/)

Free or Charity Care Clinics

- Approximately 40,000 patient visits in 2003.[6] These data are not regularly collected.

Public Health Clinics

- For information on clients served in the Health Care for the Homeless program, see the 2003 annual report at http://www.metrokc.gov/health/hchn/2003-annual-report.pdf.

Rural Health Clinics (RHC)

- Estimated 1.62 million patient visits to the 102 RHCs open in 2002.[7]
- RHCs had a median of 18% of visits from Medicaid patients, and 25% of visits from Medicare patients. [8]

Tribal Health Clinics

- See the American Indian Health Commission for Washington State website for a summary report of services available for federally recognized tribes: http://www.aihc-wa.org/AIHCDP/AIHCDP/2003_AIHCDP/Profiles.pdf .

Primary Care Residency Programs

- Compared with private providers, the programs often accept more publicly insured or uninsured patients[9]

[6] Schueler, V *Washington's Primary Care Safety Net: Structure and Availability.* Office of Community and Rural Health, Washington State Department of Health. http://www.doh.wa.gov/hsqa/ocrh/har/Wapcnet.doc

[7] *Rural Health Clinic Report (not yet released).* Washington Area Health Education Centers.

[8] *Rural Health Clinic Report (not yet released).* Washington Area Health Education Centers.

[9] Schueler, V *Washington's Primary Care Safety Net: Structure and Availability.* Office of Community and Rural Health, Washington State Department of Health. http://www.doh.wa.gov/hsqa/ocrh/har/Wapcnet.doc

Issues/Concerns

- The percentage of the state's uninsured population being seen at CMHCs has increased from 31% in 2000 to 33% in 2003.[10] CMHC funding is not adequate for the increase of uninsured residents. The growth rate of CMHCs is expected to slow or contract over the next 2-3 years.[6]

- Several sources of information exist with respect to medical access for Medicaid clients, but the state has no source of information about overall access to care. Many providers do not accept Medicaid clients for care, although this problem is difficult to quantify. Information based on Medicaid databases has indicated generally stable, if problematic, access patterns statewide with some local areas of increasing access issues. Medicaid databases do not indicate an overall increasing concentration of visits in the FQHC sector of providers.

[10] Kavoussi, Rebecca, Burchfield, Erin *Stretching the Safety Net: The Rising Uninsured at Washington's Community Health Centers.* Save Health Care in Washington. December, 2004. http://www.savehealthcareinwa.org/wedo/research/rsrch00001-exec.php

School-Based Health Centers (SBHC)

What is the service?

- School based health centers (SBHCs) provide primary preventive care to middle and high school students. Centers allow students to receive medical care in a teen-friendly environment, offering both medical and socio-emotional services
- Benefits include minimizing the healthcare gap among uninsured students, improving access to health care, reducing out of school time, and providing helpful socio-emotional resources to students.
- Websites:
    - King County: www.metrokc.gov/health/yhs/index.htm
    - www.healthinschools.org/sbhcs/
    - Kitsap County: http://www.kitsapcountyhealth.com/community_health/health_promotion/adolescent_health.htm#spectrum

How/where is the service provided?

- School-based services are located on school grounds, and serve as a point of first contact for students.

King County

- Currently, there are 16 SBHCs in rural, suburban, and urban settings of Seattle-King County
    - 10 in Seattle high schools
    - 4 in Seattle middle schools
- Centers are partnerships between Seattle Public Schools, Public Health Seattle & King County, The City of Seattle, and various community health care organizations.
- Centers are staffed by multidisciplinary teams including at least: school nurse, mental health counselor, nurse practitioner, and program coordinator/receptionist
- Services focus on prevention in the following three areas: health education, physical health, and mental health.
- Funding has come from the Seattle Families and Education Levy. This voter-approved initiative began in 1990.

Kitsap County

- Spectrum School Based Clinic opened in September 2003 (school year 2003/2004).
- Center is staffed by a family nurse practioner, health educator, school nurse, and mental health therapist in association with the school's counselor, principal, teachers, staff, and intervention specialist.
- Services focus on prevention and addressing the barriers to health care seen in this rural area.

- Center is a partnership between Spectrum SBHC and North Kitsap School District, Kitsap County Health District, Port Gamble S'Klallam Tribe, Kitsap Mental Health, and community.
- Presentations have been made to Pierce County on the success of the Spectrum SBHC; plans are being made for future presentations. Plans are also underway with Bremerton School District in exploring the feasibility of a school based health clinic.

Eligibility

- All students enrolled in schools with health centers are eligible
- Written parental consent is required except in situations where federal and/or state laws allow youth to access such treatment without parent/guardian consent.

Who is receiving the service?

Demographic Characteristics, Seattle School Based Health Centers, Academic Year 2002-2003 [1,2]

High School

- Unduplicated users: 3,707
- Total school enrollment = 12, 036
- Percent of school enrolled in SBHC= 31%
- Percent of SBHC-enrolled students using services = 52%
- 4.8 visits per student per year on average

- Of 3,707 unduplicated users, services are received by:
  - Grade 9 = 18%
  - Grade 10 = 27%
  - Grade 11 = 27%
  - Grade 12 = 22%
  - Unknown = 6%

- *Female:* 79%
- *Race/ethnicity*:
  - White = 33%
  - African American = 30%
  - Asian/PI = 20%
  - AIAN = 2%
  - Hispanic/Latino = 8 %
  - Multiethnic = 2%
  - Other unknown = 5%

Middle School

- Unduplicated users: 779
- Total school enrollment = 2,770
- Percent of school enrolled in SBHC= 28%
- Percent of SBHC enrolled students using services = 45%
- 4.3 visits per student per year on average

- Of 779 unduplicated users, services received by:
  - Grade 6 = 23%
  - Grade 7 = 35%
  - Grade 8 = 42%

- *Female:* 59%
- *Race/ethnicity*:
  - White = 31%
  - African American = 36%
  - Asian/PI = 14%
  - AIAN = 1%
  - Hispanic/Latino = 12%
  - Other unknown = 6%

[1] "Youth Health Services Annual Report 2002-2003", Public Health: Seattle & King County, Website: http://www.metrokc.gov/health/yhs/yhs-2002-2003-report.pdf Accessed 5/3/05
[2] "Seattle's School-Based Health Centers", Public Health: Seattle & King County, Website: http://www.metrokc.gov/health/yhs/thc.htm Accessed 5/3/05

Demographic Characteristics, Spectrum Clinic in Kitsap County, 2004 Totals [3]

High School and Middle School

- Unduplicated Users = 78
- Total School Enrollment = 120
- Percent of students enrolled in SBHC = No distinction made between students enrolled and students using SBHC services.
- Percent of enrolled students using SBHC services = 65%
- Served 10th, 11th, and 12th graders as well as 7th, 8th, and 9th graders from Kingston Junior High.
- *Female* = 59%
- Ethnicity breakdown = Do not break down by ethnicity. Served White, Native American, African American, Hispanic, and Mixed Race students.

Issues/concerns [4,5]

- Continued voter support of funding by "Seattle Families & Education Levy" is needed
- Expansion of funding base including alternative funding mechanisms for support of SBHC in Kitsap County is needed
- Expansion of SBHCs beyond Seattle-King County including expansion throughout Kitsap County is needed
- School populations being served should be expanded

[3] Kitsap County Health District. Website: http://www.kitsapcountyhealth.com/community_health/health_promotion/spectrum
[4] The Center for Health and Health Care in Schools, "National Survey of State SBHCs, 2001-2002". Website: http://www.healthinschools.org/sbhcs/index.asp . Accessed 4/20/05
[5] Manager, Youth Health Services", Linda St. Clair,, Public Health, Seattle&King County. June 2005.

Sexually Transmitted Disease and HIV Services

What is the service

- Publicly funded Sexually Transmitted Disease (STD) services in Washington state assist at local, state, and community levels, in the prevention and control of STD outbreaks; including HIV, Chlamydia, Syphilis, Gonorrhea, Herpes-simplex initial genital infection, and other rare STDs.
- The Department of Health has two programs: Sexually Transmitted Disease Program and HIV Program

STD Program Components

- Surveillance
- Laboratory screening
- Partner notification
- Patient management
- Risk Reduction
- Professional development

HIV Program Components

- Surveillance and Assessment
- HIV counseling, testing and partner notification
- Health education/Risk Reduction
- Community Planning
- Early Intervention Program
- Ryan White Care Services
- Title XIX HIV Case Management System

- STD Services:
  - Pregnant women are routinely screened in obstetric settings for syphilis to prevent transmission to infants. Most obstetric providers do Chlamydia and Gonorrhea screening as part of prenatal care.
  - Infertility Prevention Project: Screening of about 78,000 women for Chlamydia at approximately 140 clinics
  - Over 300,000 educational materials distributed annually around the state
- STD Program website: http://www.doh.wa.gov/cfh/STD/
  - Annual reports:
    - STD Morbidity: http://www.doh.wa.gov/cfh/STD/morbidity.htm
    - County Profiles: http://www.doh.wa.gov/cfh/STD/countyprofile_bob.htm
- HIV Services:
  - HIV Testing and Counseling is made reasonably available by each local health department
  - HIV Prevention Services are provided for persons at high risk of infection by local health departments and community-based organizations
  - Early Intervention Program (EIP) provides healthcare needed for people with HIV, including: prescription medications, medical visits and tests, help with health insurance and premiums, and assistance with Medicaid payments
  - Ryan White Care Services are supportive services for people living with HIV, including case management, mental health and substance abuse counseling, housing services, access to food and emergency financial services.
- HIV Program website: http://www.doh.wa.gov/hiv.htm
- In May of 2002 the Washington State Board of Health adopted revised rules on AIDS counseling for pregnant women. The new rules reduce barriers to routine HIV testing of pregnant women consistent with the recommendations of the Centers for Disease Control and Prevention, the Institute of Medicine, and other leading organizations.

How/where is the service provided?

- STD Services are provided by local health departments, community-based organizations, and STD clinics throughout Washington (see http://www.doh.wa.gov/cfh/STD/facility.htm)
- HIV prevention services, including counseling and testing are provided through local health departments and community-based organizations (see http://www.doh.wa.gov/cfh/HIV_AIDS/Prev_Edu/lhjlist.htm)
- EIP services can be accessed through public health clinics and contracted medical providers.
- Ryan White Care Services are provided by local health departments and community-based organizations (see http://www.doh.wa.gov/cfh/HIV_AIDS/client_svcs/default.htm)
- Maternal HIV management consultation is available at http://www.aidsinfo.nih.gov; at CDC hotline 1-800-342-AIDS; at Northwest Family Center 206-731-5100; and on Perinatal hotline 888-448-8765.

Eligibility

- STD Services: No eligibility requirements; anybody in need of services can receive them. Cost of services varies by clinic.
- HIV Prevention services are provided based on risk of HIV. Some services are on a sliding fee scale.
- EIP Program eligibility requirements:
    - Have HIV and living in Washington
    - Gross monthly income of <= $2,393 per single person
    - Resources <=$10,000 (not including home, retirement funds, or car)
- Ryan White Care Services are provided to anyone with HIV living in Washington.

Who is receiving the service?

Clients Receiving STD and HIV Services by Gender and Female Age, Race, and Ethnicity at clinics receiving some public funding[1]

(Note: Columns are not mutually exclusive. Numbers should not be totaled across columns)

	STD Testing[2]		STD/HIV Health Education[3]				HIV Testing[4]	
	Infertility Prevention Project (IPP)		Title X		State-Funded			
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Gender								
Female	77,524	88%	74,018	93%	22,210	93%	9,700	34%
Male	10,147	12%	5,919	7%	1,791	7%	19,074	66%
Total	87,671	100%	79,937	100%	24,001	100%	28,853	100%
Female Only								
Age								
15 and under	3,201	4%	2,787	4%	253	1%	319	3%
16-17	10,020	13%	8,213	11%	2,617	12%	599	6%
18-19	15,792	20%	13,071	18%	3,930	18%	849	9%
20-24	33,158	43%	26,749	36%	8,433	38%	2303	24%
25-29	7,146	9%	11,628	16%	3,884	17%	1504	15%
30-39	6,143	8%	8,666	12%	2,441	11%	2015	21%
40+	2,064	3%	2,904	4%	652	3%	2153	22%
Race								
White	52,820	72%	57,477	80%	16,385	78%	Not Available	
Black	5,324	7%	2,746	4%	1,065	5%		
AIAN[5]	1,153	2%	1,122	2%	245	1%		
Asian	4,493	6%	2,786	4%	1,064	5%		
NHOPI[6]	933	1%	805	1%	290	1%		
Other	6,247	8%	5,258	7%	890	4%		
Multiple	2,666	4%	1,624	2%	1,147	5%		
Ethnicity								
Hispanic	11,352	16%	9357	13%	1,331	7%		
Non-Hispanic	60,794	84%	64661	87%	18,653	93%		

[1] Washington State Department of Health, Infectious Disease and Reproductive Health Assessment. 8/05

[2] Clients that were screened and tested for Chlamydia and gonorrhea in family planning clinics, Planned Parenthood offices, reproductive health clinics, student health clinics, juvenile detention centers and categorical STD clinics in 2004.

[3] Clients that were provided health education to prevent STDs and/or HIVat family planning agencies in 2004.

[4] Clients that were counseled and tested for HIV at publicly-funded test sites, including HIV counseling and testing sites; STD clinics; drug treatment centers; family planning clinics; TB clinics; prisons/jails; hospitals; field visits; and Community Health Centers. Data come from the Washington State HIV counseling and testing system data, 2004. A slight difference in the total females served is due to differences between time of reporting. Age-specific information is current as of 8/16/05.

[5] American Indian/Alaska Native

[6] Native Hawaiian/Other Pacific Islander

Issues/concerns

- Chlamydia was at a record high in Washington State in 2004, further reinforcing the need for screenings, since most people who are affected are asymptomatic. [7]
- Increasing proportion of HIV cases are among women and communities of color.
- Increasing number of people living with HIV.

[7] 2004 STD Morbidity Report, Infectious Disease and Reproductive Health Office, Washington State Department of Health, 2005.

Substance Abuse Services for Pregnant Women

What is the service?

- Division of Alcohol and Substance Abuse (DASA) is the state agency providing both publicly funded treatment and prevention services for chemically dependent people and their families. Both drug and alcohol dependencies are addressed.
    - There are a variety of programs targeting substance use among pregnant and post partum women, as well as affected infants/children. Many of these are integrated and include: Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE) Services; Parent-Child Assistance Program (P-CAP); Pregnant, Postpartum, & Parenting (PPW) Residential Treatment Services; ADATSA (Alcoholism and Drug Treatment and Support Act); Housing Support Services for Pregnant, Postpartum, and Parenting Women (PPW); Safe Babies Safe Moms (formally known as Comprehensive Program Evaluation Project (CPEP) for Substance Abusing Women and Their Young Children); Crisis Nurseries; and Chemical Using Pregnant (CUP) detoxification.
- DASA collaborates with agencies, non-profit organizations, tribes, local governments to provide services for individuals and communities
- Website: http://www1.dshs.wa.gov/dasa/default.shtml

How/where is the service provided?

Housing Support Services

Description
- Up to 18 months of support services for women living in drug/alcohol free housing

Eligibility
- Pregnant/postpartum/parenting women
- <= 185% FPL
- Not using any kind of drugs
- Currently in treatment, or finished within one year, and in transitional housing

Served
- 11 sites statewide
- 149 openings available statewide
- 149 women served annually (services can be occupied for up to

Residential Treatment Services

Description
- Up to 6 months of 24-hour residential treatment settings with structured programs, along with therapeutic childcare for children

Eligibility
- High risk substance abusing parents and children <age six
- <= 185% FPL
- Women with inadequate prenatal care, have a child with FAS/FAE, or have not accessed community resources yet.

Served
- 10 sites statewide
- 150 beds available statewide
- ~610 women served in calendar year 2004
- Waiting lists vary.

Safe Babies Safe Moms [formally Comprehensive Program Evaluation Project (CPEP)]

Description
- Comprehensive services in three counties (Snohomish, Whatcom, and Benton-Franklin), for women and children up to age six; including residential treatment and housing support services
- Case management up to 3 years

Eligibility
- High risk women and young children
- <=200% FPL
- Currently accessing community resources

Served
- 3 sites statewide
- A minimum of 240 women served annually.
- Waiting lists vary.

Parent-Child Assistance Program (P-CAP)

Description
- Advocacy services: referrals, advocacy, connections to local resources, and financial assistance in six counties (King, Pierce, Yakima, Spokane, Cowlitz, and Grant)
- Case management up to the target child's third birthday.

Eligibility
- High risk women and young children
- Women with inadequate prenatal care, have a child with FAS/FAE, or have not accessed community resources yet

Served
- 6 sites statewide
- 450 women and their children served annually
- Waiting lists vary.

Crisis Nurseries

Description
- Day and respite childcare for children with parents with chemical dependency challenges

Eligibility
- Children up to age six years
- Parents using chemical dependency services

Served
- 2 sites statewide
- 83 families/143 children served (2003-2005)
- Child Haven: 105 children served
- Counties: King and Yakima

Parent Trust

Description
- Support groups for families recovering from chemical dependency

Eligibility
- High risk women and young children

Served
- 10 sites statewide
- Women who are in PPW Residential treatment can access this service.
- Usually available at Residential Treatment sites

Chemical Using Pregnant (CUP) Detoxification

Description
- Inpatient hospital program for detoxification and chemical dependency medical treatment

Eligibility
- Highest risk pregnant women
- Medically approved

Served
- 5 hospital sites statewide
- In 2004, 191 women were served.
- Waiting list is non-existent as a substance abusing pregnant woman has direct access to this service, most often within 24 hours of referral.

Fetal Alcohol Syndrome (FAS)/Fetal Alcohol Effects (FAE) Programs

Description
- *FAS Family Resource Institute (FAS*FRI)*: Non-profit partnership of professionals/parents; includes quarterly newsletter: *FAS Times*
- *FAS Diagnostic and Prevention Network (FADPN):* Community and Professional Training
- *P-CAP*: see above
- *Iceberg Newsletter:* Quarterly educational newsletter from parents/professionals

Eligibility
- High risk women and their children
- Women with FAS/FAE or with FAS/FAE children, inadequate prenatal care, and/or not yet receiving community aide
- Statewide educational resource for Washington State citizens (FAS*FRI and Iceberg)

Served
- Statewide

Additional programmatic information[1]

DASA Process

- Dual program focus on prevention and treatment
- DASA works with many community programs to be available to individuals, including treatment agencies and with 27 tribes for Native Americans.[2]
- Referrals and counseling can be found at the Alcohol and Drug 24-Hour Help Line (1-800-562-1240), and general information can be found at the Washington State Alcohol/Drug Clearinghouse (1-800-662-9111).

Eligibility

- Determined by Community Service Offices (CSO); every county has at least one CSO, some with multiple offices depending on county size.[3]
- Priority for services is given to pregnant women (turnover within 15 working days), referrals from child protective services, street youth, youth in the midst of family problems, injection drug users, and people with HIV/AIDS.

Issues/concerns

- Demand exceeds resources available for drug and alcohol abuse services, preventing those in need from receiving care. [4]
- Areas in need of attention: criminal justice, alcoholism as a chronic disease, opiate substitution treatment (methadone treatment), and substance use and aging, substance abuse and child welfare, treatment for nicotine dependence, and brief interventions in Emergency Department and Health Care Settings.
- Case management programs that extend to 5 years would sustain positive impact for a smaller subset who need additional services.

[1] Washington State Department of Health, Division of Alcohol and Substance Abuse, "Pregnant and Parenting Women (PPW) with Chemical Dependency Issues" Presentation. Contact: Sue Green. Accessed 7/05

[2] Washington State Department of Social and Health Services, "Division of Alcohol and Substance Use". Website: http://www1.dshs.wa.gov/dasa/default.shtml. Accessed 6/3/05

[3] Washington State Department of Social and Health Services, "Treatment Protocol for Chemical-Using Pregnant Women.". Division of Alcohol and Substance Abuse. November 1990

[4] DASA, "Tobacco, Alcohol, and other Drug Abuse Trends In Washington State 2004". Website accessed: http://www1.dshs.wa.gov/pdf/hrsa/dasa/2004TrendsIssues.pdf

Substance Abuse Prevention Services for Youth

What are the services?

- Division of Alcohol and Substance Abuse (DASA) is the state agency providing both publicly-funded treatment and prevention services for chemically dependent adolescents and their families. Both drug and alcohol abuse and dependencies are addressed.
- The following provides a summary of DASA Prevention Best Practices Programs offered around Washington State. There are additional programs offered through other agencies that are not addressed here.

All Stars

The All Stars program comes in two formats: middle school classroom format and community-based format. Each format reinforces the belief that risky behaviors are not normal or acceptable by the adolescent's peer group; cultivates the belief that risky behaviors do not fit with the youth' personal ideals and future aspirations; creates strong voluntary personal and public commitments to not participate in risky behaviors; strengthens relationships between the adolescent, social institutions, and significant adults; and helps parent to listen to their children, communicate clear no-use expectations about alcohol and other drugs, and support their children in working towards positive life goals.

Communities That Care

The Communities That Care (CTC) process is an operating system that provides research-based tools to help communities mobilize to promote the positive development of children and youth and to prevent adolescent problem behaviors that impede positive development including substance abuse, delinquency, teen pregnancy, school dropout, and violence.

Counter-Advertising

Research and experience demonstrate that adolescents develop attitudes, beliefs, and behaviors regarding tobacco use from peers, family members, television, and other cultural sources. Adolescents often think that tobacco use is more widespread and universally acceptable than it actually is. Advertising links tobacco use with peer acceptance, success, and good times. Media messages that promote negative images about tobacco use, reveal the number of teens who actually use tobacco, and address the unacceptableness of tobacco use should help change these perceived norms.

Creating Lasting Connections (CLC)

Creating Lasting Family Connections (CLFC) is a comprehensive family strengthening, substance abuse, and violence prevention curriculum that has scientifically demonstrated that youth and families in high-risk environments can be assisted to become strong, healthy, and supportive people. Program results, documented with children 11 to 15 years, have shown significant increases in children's resistance to the onset of substance use and reduction in use of alcohol and other drugs. CLFC provides parents and children with strong defenses against environmental risk factors by teaching appropriate skills for personal growth, family enhancement, and interpersonal communication, including refusal skills for both parents and youth.

Incredible Years

Short term objectives for parents are to improve communication skills with their children, improve limit-setting skills by means of nonviolent discipline techniques, improve their own problem-solving skills, and learn effective methods of anger management. For children, short term objectives include reduction of the frequency and number of conduct problems and improvement of prosocial skills.

Keep A Clear Mind

Keep A Clear Mind (KACM) is a parent/child substance abuse prevention program for families with children in grades four through six. This home-based program developed by the University of Arkansas uses a correspondence format and consists of four weekly lessons on alcohol, tobacco, marijuana, and tools to avoid drugs. KACM's overall goal is to increase parent/child communication regarding drug prevention and to develop specific youth beliefs and skills to refuse and avoid "gateway" drug use.

Leadership and Resiliency

The Leadership and Resiliency program is an evidence-based prevention and intervention modality affiliated with the Fairfax-Falls Church Community Services Board, Alcohol and Drug Services. The program focuses on enhancing the internal strengths and resiliency in youth, while preventing involvement in substance abuse and violence, using a three-tiered approach that involves clinical process groups, alternative activities, and community service projects. The Leadership and Resiliency program successfully reduces disciplinary problems while improving both school bonding and grades of high school youth.

Life Skills Training Program

The Life Skills Training universal classroom program is designed to address a wide range of risk and protective factors by teaching general personal and social skills in combination with drug resistance skills and normative education. The program consists of a 3-year prevention curriculum intended for middle school or junior high students. It contains 15 periods during the first year, 10 booster sessions during the second, and 5 sessions during the third. Three major content areas are covered by the Life Skills Training program: drug resistance skills and information, self-management skills, and general social skills.

Mentoring: Big Brothers/Big Sisters

Big Brothers/Big Sisters (BBBS) is a community mentoring program which matches an adult volunteer, known as a Big Brother or Big Sister, to a child, known as a Little Brother or Little Sister, with the expectation that a caring and supportive relationship will develop. Hence, the match between volunteer and child is the most important component of the intervention. Equally important, however, is the support of that match by the ongoing supervision and monitoring of the match relationship by a professional staff member. The professional staff member selects, matches, monitors, and closes the relationship with the volunteer and child, and communicates with the volunteer, parent/guardian, and the child throughout the matched relationship.

NICASA Parent Project

The Parent Project was designed specifically to meet the needs of working parents in the workplace environment to address issues of effective parenting. The goals of the program are to enrich family relationships and promote healthy environments that build resistance to social and personal dysfunction. Specifically, it focuses on the need to: establish supportive networks among working parents; improve parent/child relationships; increase ability to balance work and family life; improve corporate climate for workers; and improve parent skills in preventing and identifying substance abuse problems in themselves and their children.

Nurturing Program

The Nurturing Parenting Programs are validated, family-centered programs designed to build nurturing skills as alternatives to abusive parenting and child rearing attitudes and practices. The ultimate outcomes are to stop the generational cycle of child abuse by building nurturing parenting skills; reduce the rate of recidivism; reduce the rate of juvenile delinquency and alcohol abuse; and lower the rate of multi-para teenage pregnancies.

Parent and Family Skills Training (general)

Family functioning, structure, and values have a significant impact on children's capacity to develop prosocial skills and cope with life's challenges. Parent and family skills training can provide parents and family members with new skills. These skills enable families to better nurture and protect their children, help children develop prosocial behaviors, and train families to deal with particularly challenging children.

Parenting Skills Program

Primary program objectives are to teach parents communication skills and child management skills that will result in improved parent-child relationships and foster good psycho-social adjustment in the children. Parent use of these skills is related to freedom from drug and alcohol abuse, delinquency, teen-aged pregnancy and school dropout. Improved academic performance and pro-social skills are expected.

Positive Action

Positive Action is a recognized, research-based proven effective program that is an integrated, comprehensive, coherent program for schools, families, and communities that improves the academic achievement and multiple behaviors of children and adolescents. It is a K-12 age appropriate curriculum, a climate program, a family curriculum and parent involvement program, a community involvement program, and an after-school program. It is intensive, with lessons at each grade level from Kindergarten through 12th grade that are reinforced all day, school-wide, at home and in the community. All components can stand alone and are useful in a variety of settings besides schools. The program is easy to use. All the lessons and materials, that are colorful, interesting and meaningful, are completely planned and prepared, ready for use. Quality training ensures high level implementation. Effects cover multiple behavioral and achievement domains.

Preparing for the Drug Free Years (PDFY)

Preparing For The Drug Free Years (PDFY) is a multi-media program developed by David Hawkins, Ph.D. and Richard Catalano, Ph.D. that provides parents of children in 4th through 8th grades the knowledge and skills they need to guide their children through early adolescence. The program aims to strengthen and clarify family expectations for behavior, enhance the conditions that promote bonding in the family, and teach skills to parents and children to successfully meet the expectations of their family and resist drug use.

Project ALERT

Project ALERT is a school-based, social resistance approach to drug abuse prevention. The curriculum specifically targets cigarettes, alcohol, and marijuana use.

Project Northland
The goal of Project Northland is to prevent or reduce alcohol use among young adolescents by using a multilevel, community-wide approach. Conducted in 24 school districts in northeastern Minnesota since 1991, the intervention targets the class of 1998 (sixth-grade students in 1991). The program consists of: social-behavioral curricula in schools, peer leadership (designed to increase peer pressure resistance and social competence skills), parental involvement/education (to provide parental support and modeling), and community-wide task force activities (designed to change the larger environment).

Project SUCCESS
Project SUCCESS (Schools Using Coordinated Community Efforts to Strengthen Students) [an adaptation of the Residential Student Assistance Program model] prevents and reduces substance use among high-risk, multiproblem high school adolescents. Developed and tested with alternative school youth 14 to 18 years old, the program places highly trained professionals in schools to provide a full range of substance use prevention and early intervention services.

Project Towards No Drug Abuse
Project Towards No Drug Abuse (TND) includes 12 classroom-based lessons, approximately 40 to 50 minutes each, designed to be implemented over a four-week period, although they could be spread out over as long as five weeks on the condition that all lessons are taught. The instruction to students provides detailed information about the social and health consequences of drug use and addresses topics including instruction in active listening, effective communication skills, stress management, tobacco cessation techniques and self-control to counteract risk factors for drug abuse relevant to older teens.

Retailer-Directed Interventions
The primary goal of tobacco retailer-directed interventions is to reduce tobacco sales to minors and tobacco purchases by minors. Within this approach, research and practice is divided into three clusters: merchant and community education about adolescent tobacco use and laws prohibiting tobacco sales to minors, enactment of laws prohibiting tobacco sales to minors and enforcement of laws prohibiting tobacco sales to minors combined with merchant and community education about adolescent tobacco use and the laws prohibiting tobacco sales to minors.

Second Step: A Violence Prevention Curriculum
The Second Step program is a classroom-based social skills program for preschool through junior high students (4 to 14 years old). It reduces aggressive behaviors and increases children's social-emotional competence.

Sembrando Salud
Sembrando Salud is a culturally sensitive tobacco and alcohol use prevention program specifically adapted for migrant Hispanic youth and their families. The program is designed to improve parent-child communication skills as a way of improving and maintaining healthy youth decision-making. Sembrando Salud contains a school and family curriculum delivered by bilingual/bicultural college students.

SMART Leaders
SMART Leaders is a curriculum-based program that uses role-playing, group activities, and discussion to promote social and decision-making skills in racially diverse 14-to 17-year-olds. As participants advance in the program, they are involved in educational discussions on alcohol, tobacco, and other drugs and have the opportunity to recruit other youth for the program and assist with sessions offered to younger boys and girls. Evaluation results show the effectiveness of this multiyear approach in promoting refusal skills and creating drug-free peer leaders.

Strengthening Families Program
The Strengthening Families Program (SFP) involves elementary school aged children (6 to 12 years old) and their families in family skills training sessions. SFP uses family systems and cognitive-behavioral approaches to increase resilience and reduce risk factors for behavioral, emotional, academic, and social problems. It builds on protective factors by: improving family relationships, improving parenting skills, and increasing the youth's social and life skills.

Strengthening Families Program: 10-14

The Strengthening Families Program: For Parents and Youth 10-14 (SFP 10-14), resulted from an adaptation of the Strengthening Families Program (SFP), developed at the University of Utah. Formerly called the Iowa Strengthening Families Program, the long range goal of the curriculum is reduced substance use and behavior problems during adolescence. Intermediate objectives include improved skills in nurturing and child management by parents, improved interpersonal and personal competencies among youth, and prosocial skills in youth. Parents of all educational levels are targeted and printed materials for parents are written at an 8th grade reading level. All parent sessions, two youth, and two family sessions use videotapes portraying prosocial behaviors and are appropriate for multi-ethnic families.

Tutoring

The Too Good for Drugs (TGFD) program is a Kindergarten through Grade 12 multifaceted, interactive social influence intervention using a universal education strategy. The program is a long-term intervention that builds skills sequentially with the intention of preventing ATOD use and promoting healthy decision-making and positive, healthy youth development. This program is designed to benefit everyone in the school by providing needed education in social and emotional competencies and by reducing risk factors and building protective factors that affect most students.

12-19 Year-old Participants Enrolled in DASA Prevention Best Practice Programs
By DSHS Region and Count

County	Program Name	Clients
Region 1		
ADAMS		
	Project ALERT	1012
	Strengthening Families Program: 10-14	30
CHELAN/DOUGLAS		
	Life Skills Training Program	106
	Strengthening Families Program: 10-14	51
FERRY		
	Life Skills Training Program	4
	Mentoring: Big Brothers/Big Sisters	2
	Strengthening Families Program: 10-14	9
GRANT		
	All Stars	35
	Strengthening Families Program	21
LINCOLN		
	Life Skills Training Program	169
	Strengthening Families Program: 10-14	2
OKANOGAN		
	Strengthening Families Program: 10-14	40
PEND OREILLE		
	Life Skills Training Program	4
SPOKANE		
	Nurturing Program	10
	Positive Action	33
	Project ALERT	390
	Second Step: A Violence Prevention Curriculum	5
	Strengthening Families Program: 10-14	32
STEVENS		
	Life Skills Training Program	69
	Strengthening Families Program: 10-14	9
WHITMAN		
	Counter-Advertising	6
	Life Skills Training Program	6
Region 2		
ASOTIN		
	Nurturing Program	2
	Strengthening Families Program: 10-14	12
BENTON/FRANKLIN		
	Parents Who Care	1
	Project ALERT	213
	Strengthening Families Program: 10-14	9
KLICKITAT		

County	Program Name	Clients
	Project SUCCESS	22
WALLA WALLA		
	Keep A Clear Mind	10
	Life Skills Training Program	104
YAKIMA		
	Incredible Years	8
	Life Skills Training Program	301
	Preparing for the Drug Free Years (PDFY)	8
Region 3		
ISLAND		
	Strengthening Families Program: 10-14	66
SAN JUAN		
	Mentoring: Big Brothers/Big Sisters	10
	Strengthening Families Program: 10-14	4
SKAGIT		
	Life Skills Training Program	35
	Sembrando Salud	7
	Strengthening Families Program: 10-14	18
SNOHOMISH		
	Communities That Care	13
	Life Skills Training Program	862
	Mentoring: Big Brothers/Big Sisters	13
UPPER SKAGIT		
	Life Skills Training Program	9
WHATCOM		
	Mentoring: Big Brothers/Big Sisters	9
	Project ALERT	585
	Strengthening Families Program: 10-14	30
Region 4		
KING		
	All Stars	39
	Creating Lasting Connections (CLC)	55
	Life Skills Training Program	592
	Mentoring: Big Brothers/Big Sisters	93
	Nurturing Program	10
	Parenting Skills Program	4
	Preparing for the Drug Free Years (PDFY)	10
	Project ALERT	1538
	Strengthening Families Program: 10-14	81
Region 5		
KITSAP		
	Parent and Family Skills Training (general)	91
	Tutoring	27
PIERCE		
	Life Skills Training Program	1576

County	Program Name	Clients
	Mentoring: Big Brothers/Big Sisters	78
	Project ALERT	337
	Project Towards No Drug Abuse	287
	Tutoring	195
Region 6		
CLALLAM		
	Nurturing Program	2
	Strengthening Families Program	1
CLARK		
	Mentoring: Big Brothers/Big Sisters	4
	NICASA Parent Project	2
COWLITZ - C		
	Strengthening Families Program	1
JAMESTOWN S`KLALLAM		
	Mentoring: Big Brothers/Big Sisters	8
JEFFERSON		
	Mentoring: Big Brothers/Big Sisters	1
	Project ALERT	382
	Retailer-Directed Interventions	18
	SMART Leaders	89
	Strengthening Families Program: 10-14	8
LEWIS		
	Nurturing Program	52
	Strengthening Families Program	1
	Strengthening Families Program: 10-14	19
MASON		
	Project Northland	48
	Strengthening Families Program	12
PACIFIC		
	All Stars	181
	Project ALERT	104
SKAMANIA		
	Leadership and Resiliency	578
	Life Skills Training Program	13
	Mentoring: Big Brothers/Big Sisters	9
THURSTON		
	Parenting Wisely	1
WAHKIAKUM		
	Strengthening Families Program	1
	Strengthening Families Program: 10-14	3

Substance Abuse Treatment Services for Youth in Washington State

What are the services?

- Division of Alcohol and Substance Abuse (DASA), of the Washington State Department of Social and Health Services, is the state agency providing both publicly funded treatment and prevention services for chemically dependent adolescents and their families. Both drug and alcohol abuse and dependencies are addressed.
    - DASA contracts for and manages a comprehensive continuum of intervention, screening, assessment, and treatment services for indigent, low-income, and Medicaid-eligible youth and their families. Funded services include the Twenty-Four Hour Helpline and Teen Line, school-based intervention services through Office of the Superintendent of Public Instruction (OSPI), contracts with 39 counties for outpatient assessment and treatment services, and direct contracts with public and private agencies for stabilization/detoxification and residential services.
- DASA collaborates with agencies, non-profit organizations, tribes, local governments to provide services for individuals and communities
- Helpful Publications on the Website: ***A Guide for Parents: Chemical Dependency Treatment Options for Minors Under Age 18; and Referral and Resource Guide for Adolescent Chemical Dependency Treatment*** (Both publications available in bulk from the Washington State Alcohol/Drug Clearinghouse: 1-800-662-9111, or at clearinghouse@adhl.org.)
- Website: http://www1.dshs.wa.gov/dasa/default.shtml

How/where are services provided?

Alcohol Drug Twenty-Four Hour Help Line and Teen Line

Prevention and Intervention Services in Schools

Description

Alcohol Drug 24 Hour Helpline, and Teen Line: offer phone assistance on referrals, resources, teen support for drug and alcohol problems.

Prevention/Intervention Services (OSPI) funded through local, state, and federal funds, places prevention/intervention specialists in schools for comprehensive student assistance programs that address problems associated with substance use, early prevention and intervention, assistance in referrals to assessment and treatment, and strengthening transition back to school for students who have had problems of alcohol and other drug abuse and dependency. (See additional description of school-based services in *Substance Abuse Prevention Services for Youth* chapter.)

Eligibility

- Help Line and Teen Line open to all residents.
- P/I services, see Prevention Description.

Stabilization and Detoxification Services

Description
The purpose is to provide a safe, temporary, protective environment for at-risk/runaway youth who are experiencing harmful effects of intoxication and/or withdrawal from alcohol and other drugs, in conjunction with emotional and behavioral crisis, including co-existing or undetermined mental health symptoms. For youth age 13 – 17, it addresses the needs of and treatment outcomes for youth who need chemical dependency and other treatment services but who may not be able to access these services due to acute intoxication and medical, psychological, and behavioral problems associated with their alcohol/drug use.

Eligibility
Open to all youth regardless of income or financial resources.

Served
Approximately 354 youth between ages of 12 – 17 received detox/stabilization services in 2003.
Seven sites throughout the State serving regional populations.
Note: Parental consent is recommended but not required since this is not a treatment service.

Screening, Assessment, Outpatient Services

Description
A state certified program which provides assessments and alcohol/drug counseling for youth and families, including outreach, case management, group and individual, and referral to treatment. Includes mis-use through abuse of alcohol and drugs, aftercare services post-residential treatment.
Includes Group Care Enhancement outpatient services out-stationed at youth group homes, programs not certified for these services, as a way to reduce barriers and increase access to treatment. DASA sub-contracts with all 39 counties.
Eligibility
Youth age 10 - 18, whose family incomes are below 200% of the federal poverty level, and who do not have access to treatment through health insurance mechanisms.
Served
See description in **Who Is Receiving Services.**
Note: Parental consent required for any treatment of minor under age 13; minor age 13 – 17 may consent to outpatient services. (See Youth Guide, Parent Guide for detailed information, agency provider lists).

Residential and Recovery House Services

Description
DASA contracts with residential providers for different modalities due to addiction and other life issues and their severity, and whether a "secure" setting is needed.
Level I: for youth with primary diagnosis of chemical dependency with less complicating mental health, other emotional, behavioral problems. Length of stay variable 30 – 45 days.
Level II: have primary diagnosis of chemical dependency and symptoms of mental health diagnosis or problems requiring concurrent management. Variable length of stay 30 – 90 days.
Secure settings: some providers have internal and external mechanisms, and staff security designed to reduce youth running away from treatment.
Recovery House: for youth needing sober supportive home after residential treatment stay, treatment focus is longer term recovery and life skills, relapse prevention. Length of stay variable up to 120 days.
Total beds: 182 (includes treatment expansion beds)
Eligibility
Same as Outpatient Services. Regional providers but open to all youth in state.
Served
See description in **Who Is Receiving Services.**
Note: Parental consent required for any minor under age 18; except "self-consent for youth who meet definition of Child In Need of Services (CHINS) when parent unable or unwilling to provide consent.

Who is receiving the service?

Overall, youth clients are referred from multiple systems, and assessed for need of chemical dependency treatment. They include youth with family incomes below 200% of the federal poverty level, who do not have access to treatment through health insurance mechanisms. Youth who are admitted to DASA publicly funded treatment programs have many serious and complex problems requiring a coordinated, multi-agency approach. Data from the 2003 Treatment and Assessment Reports Generation Tool (TARGET) provides a description of the population receiving treatment.

- **Gender**: 62% male and 38% female.
- **Race**: 57% White (Non-Hispanic), 6% Black, 11% Hispanic, 6% Native American, 2% Asian/Pacific Islander, 18% Other.
- **Age**: 41% between the ages of 11 and 15 years.
- **Schooling**: 15% not enrolled in school; and 15% dropped out/suspended from school.
- **Substance use history**: 94% began using their primary substance between the ages of 11 and 15; 6% had used needles to inject illicit drugs; 71% were chemically dependent at time of admission. Marijuana is the most frequently cited drug of abuse in youth admissions.
- **Type of treatment services**: The majority of youth admissions are for outpatient services: 53% outpatient, 24% intensive outpatient, 18% intensive inpatient, and 4% recovery house services.
- **Mental health needs**: 15% had a diagnosed mental disability; 16% were currently receiving mental health services; 15% were currently on prescribed psychiatric medications.
- **Criminal history**: 48% were on parole or probation at the time of substance abuse treatment
- **Other socioeconomic factors**: 28% had run away from home at least once in their lifetime; 22% had been a victim of domestic violence; 31% used the emergency room for one or more visits in the last year.

While youth vary in their ethnic diversity, data gathered from TARGET (DASA database and the DASA Treatment Analyzer) revealed that over 99% of youth admitted for treatment for state fiscal year 2003 reported that they had functional English speaking and reading skills.

The Treatment Gap:

In 2003, 5,875 youth received treatment services by DASA, out of an estimated 24,981 eligible individuals needing and eligible for DASA-funded treatment. The following table illustrates the treatment gap, or underserved need. (DASA 2004 Tobacco, Alcohol, and Other Drug Abuse Trends in Washington State).

Target Population	*Needing & Eligible for DASA-Funded Treatment*	*Received Treatment with DASA-Funded Support*	*Number of Eligible Individuals Unserved*	*Treatment Gap Rate (Unserved Need)*
Adolescents	**2003**	**2003**	**2003**	**2003**
Ages 12 – 17	**24,981**	**5,875**	**19,106**	**76.5%**

Priority populations:

Services address and prioritize youth who are on the street, homeless, running away from home, injection drug using, and pregnant and parenting.

Assistance with Transportation:

Financial assistance is available to those youth and families who qualify for residential treatment, and who are in most need of assistance with treatment program family activities due to distance and other barriers. (See Family Hardship in Youth Referral Guide)

Issues/challenges for Youth Treatment System:

- Co-Occurring mental health conditions
- Increasing need for techniques to improve engagement, retention, and completion using cognitive behavioral approaches compatible with alcohol and drug addiction treatment.
- Increasing referrals from Juvenile Justice sources, such as local courts, drug courts, and community placement of offenders.
- Limited capacity and funding.
- Public funding for only 24% of those indigent, low-income youth and families needing treatment.
- Long waiting lists result in missing the "window of opportunity" for admitting to treatment services.
- Increased need for "secure" facilities.
- Primary marijuana abuse and addiction.
- Increases in methamphetamine use.
- Lower age of first use and level of maturity.
- Severity of alcoholism and drug addiction.
- Improving responsiveness and sensitivity to the diverse ethnic and cultural lives of youth and families.

Treatment Works – Outcomes One Year After Treatment:

(Washington State Division of Alcohol and Substance Abuse One-Year Adolescent Outcomes Report 1997; Treatment Outcomes for Youth Admitted to Residential Chemical Dependency Treatment Under the Provisions of the "Becca" Bill 1997)

- Declines in school and work problems
- Improved school performance, attendance, and academic achievement
- Declines in psychiatric symptoms
- Declines in legal involvement
- Declines in medical service utilization

How to Refer a Youth to Treatment:

Each DASA-contracted youth provider is responsible for determining a youth's clinical and financial eligibility for treatment at that contracted facility. Those youth who already have medical coupons are approved for DASA funding. Youth who are low-income may be eligible for DASA-funding, and those families with some third party insurance who may not be able to afford costs of treatment not covered by insurance may also be eligible for partial or full funding.

Generally it is best to refer a youth to an outpatient treatment program for an initial assessment of chemical dependency, although if the need for residential treatment has been established, youth may be referred directly to a contracted residential facility, with arrangements for continuing care at a local outpatient provider.

For more detailed information about referral and financial processes, and lists of programs, age of consent issues, refer to:

A Guide for Parents: Chemical Dependency Treatment Options for Minors Under Age 18; and Referral and Resource Guide for Adolescent Chemical Dependency Treatment located on DASA website or from the Washington State Alcohol Drug Clearinghouse.

For assistance in finding treatment resources:

Cyndi Beemer	DASA Region One Treatment Manager	**(509) 329-3732**
Eric Larson	DASA Region Two Treatment Manager	**(509) 225-6232**
Melinda Trujillo	DASA Region Three Regional Manager	**(360) 658-6862**
Bob Leonard	DASA Region Four Treatment Manager	**(206) 272-2188**
Pamala Sacks-Lawlar	DASA Region Five Treatment Manager	**(253) 476-7058**
Ruth Leonard	DASA Region Six Treatment Manager	**(360) 725-3742**
Stephen Bogan	DASA Youth Treatment System Manager	**(360) 725-3707**

24-HOUR ALCOHOL/DRUG HELP-LINE (206) 722-4222 or
Call **TOLL FREE** (WA only) **1-800-562-1240**

Teen Pregnancy Prevention

What is the service?

- Title V MCH Block Grant funds and Title V, Section 510 Abstinence Education funds provide teen pregnancy prevention services to youth of Washington through a variety of outreach and educational services. Abstinence Education funding provides information solely on abstinence and enhancing interpersonal communication, whereas Block Grant funds cover a wider range of topics including access to contraception, family planning methods, and youth development.

Teen Pregnancy Prevention Projects

Description:

- High-risk youth receive family planning services, education, counseling, and mentoring through the Teen Pregnancy Prevention Projects. Youth are educated on topics ranging from HIV and sexually transmitted disease (STD) prevention to appropriate birth control and contraceptive methods to increasing parent-caregiver communication. These projects employ the youth development approach, which assumes that adolescents must develop basic competencies and skills to choose health-enhancing behaviors and become successful adults. The project sites are evaluated to determine efficacy and further enhance program designs specific to community needs and the target population.

How/where provided

- Implemented in five counties: King, Mason, Lewis, Okanogan and Grays Harbor
- Funding is provided to local family planning agencies, community-based organizations, and local health departments.

Eligibility: All youth ages 10-19 years old are eligible for services

Target Audience

- Approximately 350 youth clients were served through these projects. These projects are funded annually and last from August 1st through July 31st.

Abstinence-based Public Awareness Campaign

Description

- Campaign targets youth by encouraging them to not engage in sexual activity while emphasizing that parents of young teens should talk to their children about delaying sex. Qualitative data through statewide focus groups conducted with youth and parents in 2004 served as the foundation for media-based campaign messages. Pre and post test surveys of youth and parents will determine campaign effectiveness and allow for message enhancement.
- Media spots include two television spots for youth and one for parents. Youth spots encourage youth not to have sex, while the parent spot provides parents ways to talk to their children about delaying sex. Radio spots for parents and youth (translated into Spanish as well), are also aired in various radio stations throughout the state.
- The campaign timeline is April 18 through September 11, 2005 and spots are aired on various channels, including, but not limited to MTV, ABC Family, Cartoon Network, WB, NBC etc.

How/where service provided

- The public awareness campaign is implemented statewide and target audiences have access to messages through television, radio, billboards, and cinema screen ads.

Eligibility: All youth ages 10-19 years old and their parents are eligible for services

Target Audience

- Estimated audience: All youth ages 10 through 14 and parents of young teens are potential target audience for the campaign.
- Target areas include: Seattle/Tacoma which includes north to Bellingham, south to Olympia, west to the Olympic peninsula and east to Wenatchee; Southwest WA which includes Vancouver north to Olympia and East to Goldendale; Central WA which includes Yakima and the Tri-Cities; Eastern WA which includes Spokane, Walla Walla, Pullman, Colville, Moses Lake and north to the border.
- Billboard (June 1 to August 31) and Cinema screen (July 1 through July 31) ads are strategically placed throughout the state as well.
- Areas with billboards include, Anacortes (1), Aberdeen (2), Bremerton (2), Centralia/Chehalis (1), Ellensburg (1), Long Beach (1), Longview (1), Vancouver (3), Port Angeles (1), Colville (1), Newport (1). Cinema screen spots were bought in these areas: Walla Walla (12), Sunnyside (12), Yakima (20), Ellensburg (9), Pullman (8), Clarkston (12), Colville (1).

Abstinence-based Media Literacy Curriculum

Description:

- Sites implementing an abstinence-based media literacy curriculum targeting middle school youth were successfully evaluated through pilot testing in 2004. The current goal is to provide the same curriculum to communities and schools through a competitive process by fall 2005. The curriculum is a peer-to-peer program that enables youth to deconstruct various media messages, while encouraging them to abstain from sexual activity in order to avoid unintended pregnancy, STDs, and HIV.

How/where service provided

- The media literacy curriculum will be implemented in 10 communities across the state. Curriculum training for youth will be provided by the University of Washington, College of Education.

Eligibility: All youth ages 10-19 years old are eligible for services

Target Audience

- 532 youth participated in the media literacy curriculum in six pilot test sites across the state in 2004. Sites included Port Angeles, Spokane, Seattle, Yakima, Des Moines, Naches.
- Approximately 10 sites statewide will be funded in 2005, ranging from 10 to 40 participants per site.

Sexuality Education Guidelines

Description

- The January 2005 Guidelines for Sexual Health Information and Disease Prevention created by the Department of Health and the Office of Superintendent of Public Instruction provides a common framework for all educators and teachers providing comprehensive sexuality education to youth. While the voluntary guidelines promote abstinence as the safest method to avoid pregnancy and STDs, they also provide information on contraception for youth who choose to become sexually active.

Eligibility: All youth ages 10-19 years old are eligible for services

How/where service provided

- Statewide

Target Audience

- All health educators, teachers, and parents/caregivers are encouraged to use the Guidelines as a framework to teach comprehensive sexuality education.
- The Guidelines were distributed to all local health departments, Nursing Directors, local family planning agencies, tribal health programs, and all ESDs. Unfortunately, there is no way to track how many people or who is accessing the guidelines through our website.

Issues/Concerns

- Nationally and within Washington State, abstinence education funding has been on the increase, whereas dollars for comprehensive services and education is limited. DOH also lost state funding in 2003 that partially supported teen pregnancy prevention projects across the state.
- The federal 8-part abstinence education definition is very limiting in its scope and only three out of the eight parts have any factual evidence behind them. DOH is particularly concerned, now that the program has been transferred from the Maternal and Child Health Bureau to the Administration for Children and Families, that future program guidance might enforce equal emphasis on all eight parts of the abstinence education definition.
- Although teen pregnancy rates have been declining steadily over the last decade in Washington, there is concern over STD and HIV rates among the adolescent population and disparities across the state. Furthermore, there is no reliable statewide data in Washington to measure change in sexual activity. Data exist on teen pregnancies, births, abortions, and sexually transmitted diseases. Reduction in teen pregnancy rates is a surrogate measure for sexual activity and is the indicator used to evaluate these programs.

Tobacco Prevention & Treatment Services for Pregnant Women

What is the service?

- Publicly funded interventions aimed at assisting pregnant and postpartum women to quit smoking, reduce tobacco use, and avoid secondhand smoke exposures have been incorporated into the medical package for pregnant and postpartum women on Medicaid as well as First Steps Maternity Support Services for low-income pregnant women. [See *First Steps* Services for additional information on this program]
- These services are the result of collaborative efforts of staff from the Department of Health Maternal and Infant Health Program, Tobacco Prevention and Control Program, Women Infants and Children Nutrition Program and the Department of Social and Health Services Health Services and Recovery Administration.

First Steps Tobacco Cessation Services

Description
First Steps providers are required to ask each client about tobacco usage and secondhand smoke exposure throughout her pregnancy and two months postpartum, and each client is offered an appropriate and individualized intervention. Providers are trained in motivational interviewing and systems change. Some First Steps providers have been trained about and are piloting the use of the Washington Tobacco QuitLine (WAQL) Fax Referral Program (see below) to enhance tobacco cessation interventions.

How/where provided
First Steps visits are conducted in First Steps agency offices or in the woman's home.

Eligibility
All pregnant women on Medicaid are eligible for First Steps Maternity Support Services.

Medicaid Smoking Cessation Benefit for Pregnant Women

Description
Washington Medicaid covers smoking cessation counseling for pregnant women as part of its fee-for-service scope of benefits. Included in this benefit is payment for Zyban, a pharmaceutical treatment for nicotine addition, when appropriate. DOH staff provide training and consultation about the benefit and guidelines for prescribing Zyban, including the development of a provider reference card which has been distributed to all obstetrical providers statewide.

How/where provided
Services are provided statewide by medical providers in their offices.

Eligibility
Low income (< 185% federal poverty level) pregnant women on Medicaid; Zyban is only covered for pregnant women over 18 years.

QuitLine

Description
The Department of Health funds the toll-free Washington Tobacco QuitLine (WAQL)(1-877-270-STOP) or www.quitline.com, which provides individual counseling, referrals to local cessation programs, and tobacco cessation kits. The QuitLine has a specialized intervention protocol for pregnant women. Pregnant women regardless of health coverage can be enrolled in the Free and Clear telephone multi-week intensive program.

In June 2005, the WAQL implemented the QuitLine Fax Referral Program. This program aims to reduce the barriers faced by health care providers in helping tobacco users quit by integrating the cessation activities into routine health care. The program is available to obstetric providers during the initial implementation phase. The medical provider asks and documents tobacco use, advises users to quit, and assesses interest in quitting. Pregnant women interested in quitting are directly referred to the WAQL using a faxed referral form. The WAQL confirms the referral and contacts the pregnant woman to assist in developing a quit plan and to arrange referrals. After the implementation phase, fax referral will be expanded to all First Steps providers.

How/where provided
Statewide by phone

Eligibility
Any Washington State smoker is eligible for the QuitLine, only pregnant women are eligible for the fax referral at this time.

Who is Receiving the Services

Pregnant Women Receiving Publicly Funded Smoking Cessation Services in Washington, 2004						
	First Steps Maternity Support Services[1]		Medicaid[2]		Washington QuitLine [3]	
Age	#	%	#	%	#	%
< 18	758	7.5%	26	7.7%	n/a	n/a
18-19	1,315	13.0%	42	12.5%	n/a	n/a
20-24	3,704	36.5%	143	42.4%	n/a	n/a
25-34	3,666	36.1%	101	30.0%	n/a	n/a
35-44	701	6.9%	22	6.5%	n/a	n/a
45+	8	0.1%	3	0.9%	n/a	n/a
Total	10,152	100%	337	100%	234	100%

[1] These data should be interpreted with caution. At this point in time, First Steps providers are not consistently billing for their assessment efforts. Conlon D. Tobacco Cessation Performance Measure (S9075) Total Clients by Age of Client, Fiscal Year 2005 Dates of Service. Washington State Department of Social and Health Services, Health and Recovery Services Administration, 11/16/05
[2] This includes Zyban prescriptions and/or smoking cessation counseling provided to pregnant/post-partum women in 2004 and paid through August 2005. Conlon D. Zyban prescriptions and/or smoking cessation counseling – pregnant/post-partum women, clients served and expenditures by client age calendar year 2004 dates of service. Washington State Department of Social and Health Services, Health and Recovery Services Administration, 9/2/05.
[3] Data are from calls form the Washington QuitLine, 2004.

Issues/Concerns

- Pregnant women on Medicaid have high rates of tobacco use.
- Many women quit smoking just before or during pregnancy, however relapse rates approach 70%.[4]
- Many First Steps and medical providers still do not know about Medicaid's counseling benefit and/or do not bill for assessment and cessation services.
- Need to develop strategies to reach primary care providers who serve women on Medicaid to increase the number of providers who complete a brief intervention and refer women to the WAQL, preferably prior to pregnancy.
- Medicaid clients on Healthy Options are not eligible for the counseling benefit. Healthy Options contracts require a smoking cessation intervention for all pregnant women but this is not specified. Five plans currently cover Zyban for Pregnant women.
- There remains controversy regarding the use of Nicotine Replacement Therapy and Zyban during pregnancy.
- DOH will expand the fax referral program to all medical providers to increase the number of all Medicaid recipients who smoke who access the WAQL services.

[4] Goldenberg RL, Klerman LV et al. Smoking in Pregnancy: final thoughts. Tobacco Control 2000; 9 (Suppl III):iii85-iii86.

Tobacco Prevention & Treatment Services for Youth

What is the service?

- Through the Tobacco Prevention and Control Program of Washington State, prevention and control activities take place through a variety of partners, including community and tribal programs, public awareness and education, school programs, quit programs, policy and enforcement, and assessment and evaluation.
- Goals include: Increasing tobacco cessation, eliminating exposure to secondhand smoke, preventing youth from initiating tobacco use, and identifying and eliminating tobacco-related disparities in high-risk groups.[1]
- Website: http://www.doh.wa.gov/tobacco/

Community and Tribal Programs

Description
Washington State funds tobacco prevention and control programs around the state.

How/where provided
Programs provided in all 39 counties, in 27 of the 29 federally-recognized tribes, and in five high-risk communities.

Target Audience
Washington State residents

Public Awareness and Education

Description
A combination of creative multimedia approaches used to raise awareness about the dangers of smoking and secondhand smoke, to prevent youth from smoking, and help adults quit.

How/where provided
Through media sources such as TV, newspapers, internet, billboards, radio, and locations where youth congregate such as malls and community centers.
Unfiltered TV: Media ads to reach youth; http://www.unfilteredtv.com/

Target Audience
Youth ages 11-14 years old currently targeted by newest campaign "Kissing a smoker is just as gross", which began in October 2005.
Since it's inception in 1999, there are 65,000 fewer youth smoking in Washington State

[1] Washington State Department of Health, "Tobacco Prevention and Control Program Progress Report" March 2005.

School Programs

Description
Funding is provided to help schools establish smoking cessation programs for students, provide information to families, train school staff, distribute evidence-based curriculum, and facilitate the enforcement and improvement of tobacco-free policies.

How/where provided

- The state's nine Educational Service Districts equip Washington's 296 school districts, in partnership with the Office of the Superintendent for Public Instruction, non-profit agencies, local health departments, and other local agencies.
- Monthly progress reports are submitted to the Department of Health from each Educational Service District, addressing activities within each of its participating school districts.

Eligibility
All students are eligible

Target Audience
Grades 5^{th}-9^{th} are targeted, since this is the age most youth begin smoking

Quit Programs

Description
The Department of Health funds the toll-free Washington Tobacco QuitLine (WAQL) (1-877-270-STOP or www.quitline.com) which provides individual counseling, referrals to local cessation programs, and tobacco cessation kits.

How/where provided
In addition to the WAQL, health care providers are trained to assist patients with cessation activities.

Eligibility
Any Washington State smoker

Target Audience
Current smokers

Policy and Enforcement

Description
State and Federal laws are enforced, and local efforts supported, through the partnerships between the Department of Health, state Attorney General, Liquor Control Board, and local law enforcement agencies.

How/where provided
Policies address the dangers of secondhand smoke, and facilitate the reduction of advertising and targeting of youth.
Retailers are educated about federal requirements, and compliance checks conducted, to ensure that tobacco sales to youth stay below 20 percent of total sales.
In 2004 random checks, youth were able to purchase tobacco in 11.7% of attempts.

Target Audience
Retailers and adults targeted to reduce access and availability of tobacco products

Who is Receiving the Services [2]

- In 2004, over half of students reported receiving information about the dangers of tobacco in school during the past year: [3]
    - 6th graders: 84%
    - 8th graders: 80%
    - 10th graders: 74%
    - 12th graders: 55%

- In 2004, over three-fourths of students report hearing or seeing commercials about the dangers of cigarette smoking in the last month:
    - 8th graders: 76%
    - 10th graders: 79%
    - 12th graders: 80%

Media [4]

- Total TV Prevention spots airing in 2005 = 23,912
- Total R Prevention spots airing in 2005 = 24,572

Highlights [1]

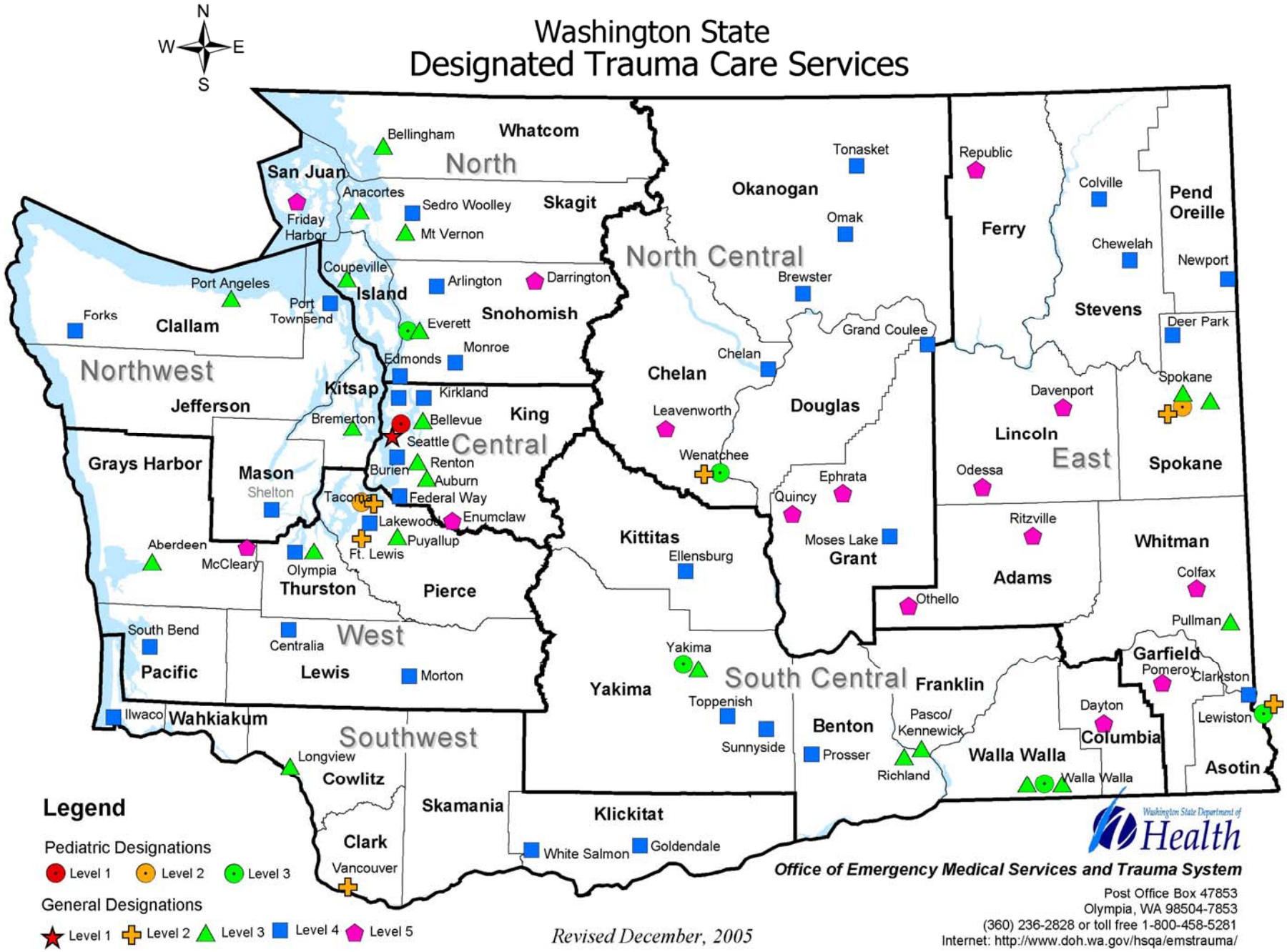
Smoking among youth has decreased since 1999:
- 6th graders – 57% decrease
- 8th graders – 49% decrease
- 10th graders – 48% decrease
- 12th graders – 44% decrease

[2] Washington State Department of Health, Tobacco Prevention and Control Program. "Statewide Tobacco Use Rates". Website: http://www.doh.wa.gov/tobacco/fact_sheets/programfactsandfigures.htm. Accessed 10/26/05
[3] Washington State Healthy Youth Survey 2004. Washington State Office of Superintendent of Public Instruction, Department of Health, Department of Social and Health Services, and Department of Community, Trade, and Economic Development and RMC Research Corporation. Website: http://www3.doh.wa.gov/HYS/ASPX/HYSQuery.aspx

[4] 2005 Ad Spot Database – Maintained by Sedgewick Road.

Issues/Concerns [1]

- Approximately 45 Washington kids still begin smoking each day, despite the progress made so far
- Healthcare resources are continually drained by tobacco-related diseases
- Existence of health disparities are affecting communities disproportionately
- Over 100,000 non-smokers are exposed to workplace secondhand smoke
- Over 10% of babies are born to mothers who smoked during their pregnancy
- Sustainable funding is required to maintain decreasing tobacco use rates and to counter tobacco industry advertising


Washington State
Designated Trauma Care Services
N
W
E
S
Whatcom
Bellingham
North
San Juan
Anacortes
Sedro Woolley
Skagit
Friday Harbor
Mt Vernon
Coupeville
Island
Arlington
Darrington
Port Angeles
Port Townsend
Snohomish
Forks
Clallam
Everett
Monroe
Edmonds
Northwest
Kitsap
Kirkland
Jefferson
Bremerton
Bellevue
King
Seattle
Central
Grays Harbor
Mason
Shelton
Renton
Burien
Auburn
Tacoma
Federal Way
Lakewood
Enumclaw
Aberdeen
McCleary
Puyallup
Ft. Lewis
Olympia
Thurston
Pierce
South Bend
Centralia
West
Pacific
Lewis
Morton
Ilwaco
Wahkiakum
Southwest
Longview
Cowlitz
Skamania
Clark
Vancouver
Klickitat
White Salmon
Goldendale
Okanogan
Tonasket
Omak
North Central
Brewster
Grand Coulee
Chelan
Chelan
Leavenworth
Douglas
Wenatchee
Ephrata
Quincy
Moses Lake
Grant
Ellensburg
Kittitas
Yakima
Yakima
Toppenish
Sunnyside
South Central
Benton
Prosser
Pasco/
Kennewick
Richland
Franklin
Walla Walla
Walla Walla
Republic
Ferry
Colville
Pend
Oreille
Chewelah
Newport
Stevens
Deer Park
Spokane
Davenport
Lincoln
East
Spokane
Odessa
Ritzville
Adams
Whitman
Colfax
Othello
Pullman
Garfield
Pomeroy
Clarkston
Dayton
Columbia
Lewiston
Asotin
Legend
Pediatric Designations
Level 1
Level 2
Level 3
General Designations
Level 1
Level 2
Level 3
Level 4
Level 5
Revised December, 2005
Washington State Department of Health
Office of Emergency Medical Services and Trauma System
Post Office Box 47853
Olympia, WA 98504-7853
(360) 236-2828 or toll free 1-800-458-5281
Internet: http://www.doh.wa.gov/hsqa/emstrauma/

Trauma Service Designation Definitions

Level I (Adult and Pediatric) Trauma Service – provides the highest level of definitive and comprehensive surgical and medical care for trauma patients with multiple and complex injuries requiring the most specialized care. Trauma-trained emergency physicians, registered nurses, and general surgeons are in-house and available to the trauma patient within 5 minutes to initiate resuscitation and stabilization, and to direct patient care. A Level I must conduct applicable trauma research and injury prevention activities, provide statewide professional and community education, and consultative community outreach services.

Level II (Adult and Pediatric) Trauma Service – provides definitive comprehensive surgical and medical care for multi-system trauma patients. Trauma-trained emergency physicians and registered nurses are in-house and available to the trauma patient within 5 minutes to initiate resuscitation and stabilization. A trauma trained general surgeon is available within 20 minutes to direct patient care. A broad range of specialists, comprehensive diagnostic capabilities, and support services are available. Injury prevention activities, professional and community education, and consultative community outreach services are provided.

Level III (Adult and Pediatric) Trauma Service – provides comprehensive surgical and medical care for trauma patients. Trauma-trained emergency physicians and registered nurses are in-house and available within 5 minutes to initiate resuscitation and stabilization. A trauma trained general surgeon is available within 30 minutes to direct patient care. The general surgeon may provide treatment including surgery, or initiate transfer to a higher-level trauma service. Select specialty, diagnostic, and support services are available. Injury prevention activities are provided.

Level IV Trauma Service – provides initial resuscitation and stabilization. Trauma-trained registered nurses are in-house and available within 5 minutes to initiate resuscitation and stabilization, and trauma-trained physicians are on-call and available within 20 minutes to provide resuscitation, stabilization, and treatment, and to initiate transfer. Trauma-trained general surgeons and trauma critical care services may be available, but are not required. Standard diagnostic and support services are provided.

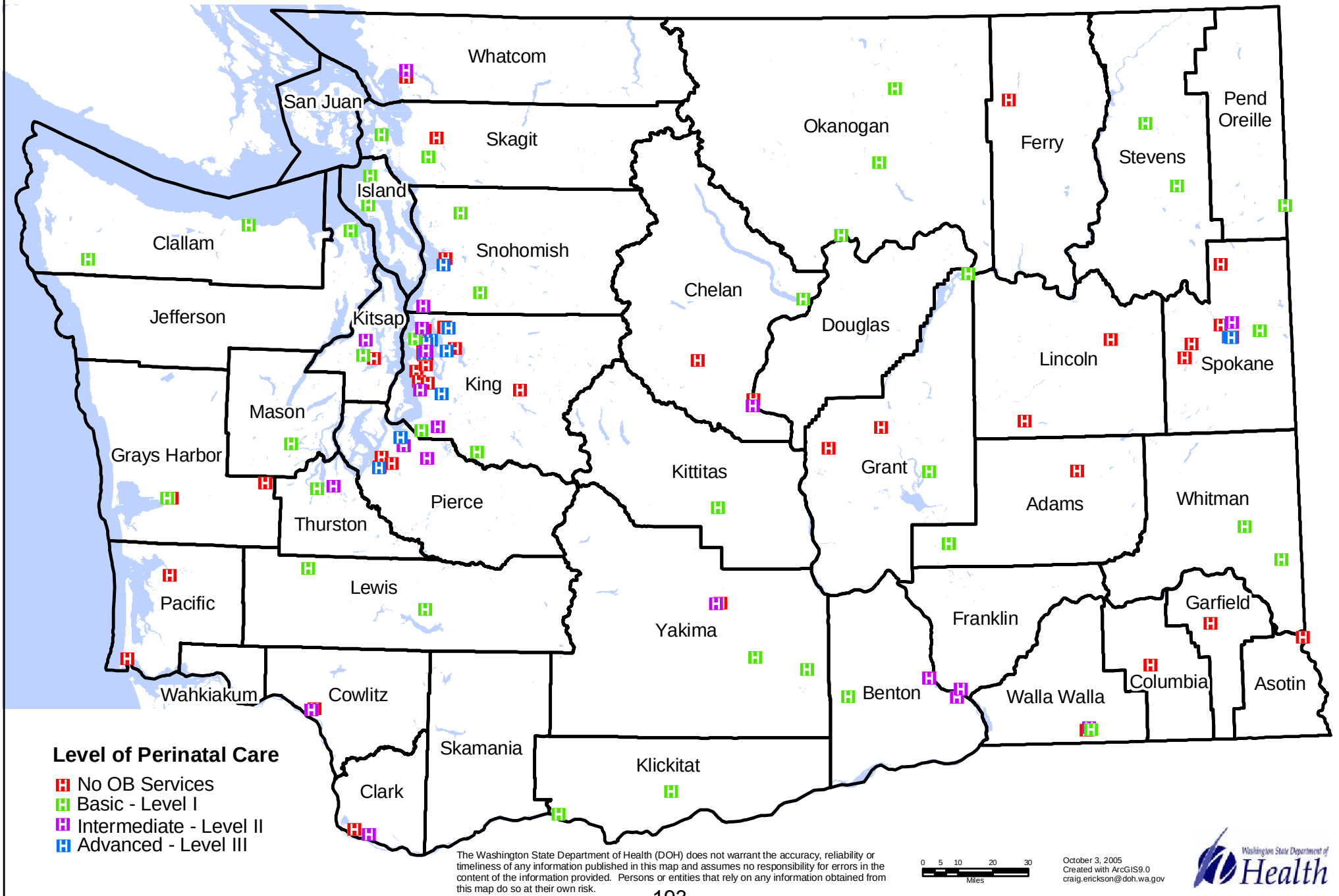
Level V Trauma Service – provides initial resuscitation, stabilization, and transfer of trauma patients. Trauma-trained physicians, physician assistants, or advanced registered nurse practitioners are available within 20 minutes. Level V facilities are rural hospitals or clinics.

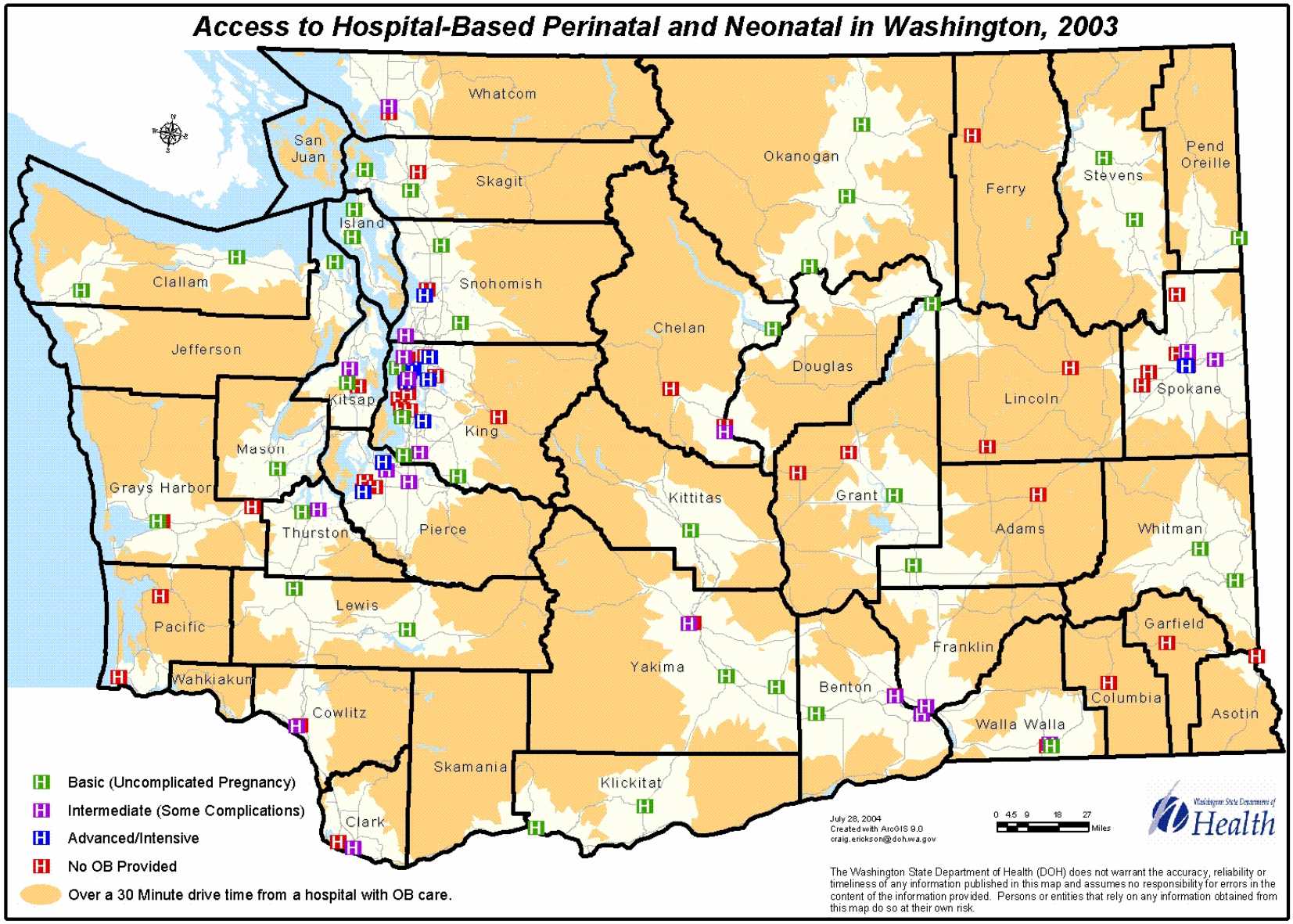
Level I (Adult and Pediatric) Trauma Rehabilitation Service – provides in-patient rehabilitative treatment to trauma patients with traumatic brain injuries, spinal cord injuries, complicated amputations, and other diagnoses resulting in moderate to severe functional impairment.

Level II Trauma Rehabilitation Service – provides in-patient rehabilitative treatment to trauma patients with musculoskeletal trauma, peripheral nerve injuries, lower extremity amputations, and other diagnoses resulting in moderate to severe functional impairment.

Level III Trauma Rehabilitation Service – provides out-patient rehabilitative treatment to trauma patients with limited musculoskeletal injuries, peripheral nerve injuries, uncomplicated lower extremity amputations, and other diagnoses resulting in minimal to moderate functional impairment.

Washington State Hospitals, 2005




Access to Hospital-Based Perinatal and Neonatal in Washington, 2003
Whatcom
San Juan
Skagit
Island
Snohomish
Clallam
Jefferson
Kitsap
King
Mason
Grays Harbor
Thurston
Pierce
Lewis
Pacific
Wahkiakum
Cowlitz
Skamania
Clark
Okanogan
Ferry
Stevens
Pend Oreille
Chelan
Douglas
Lincoln
Spokane
Kittitas
Grant
Adams
Whitman
Yakima
Franklin
Benton
Garfield
Columbia
Walla Walla
Asotin
Klickitat
Basic (Uncomplicated Pregnancy)
Intermediate (Some Complications)
Advanced/Intensive
No OB Provided
Over a 30 Minute drive time from a hospital with OB care.
July 28, 2004
Created with ArcGIS 9.0
craig.erickson@doh.wa.gov
0 4.5 9 18 27
Miles
Washington State Department of Health
The Washington State Department of Health (DOH) does not warrant the accuracy, reliability or timeliness of any information published in this map and assumes no responsibility for errors in the content of the information provided. Persons or entities that rely on any information obtained from this map do so at their own risk.

Data Sources

Behavioral Risk Factor Surveillance System (BRFSS): BRFSS is a national telephone survey of adults 18 and over who live in households with telephones. BRFSS monitors modifiable risk factors for chronic diseases and other leading causes of death, including nutrition, exercise, tobacco use, injury control, and use of preventive services as well as knowledge and attitudes, demographics, general health status, and access to health care. Topics vary by year as well as whether they are core CDC topics or state-added modules. Households are randomly selected to be called and then, once reached, one adult from the household is randomly selected to be interviewed. Data are not available at the county level. [Counties oversampled in 2003 and 2004] The Washington State BRFSS website is http://www.doh.wa.gov/EHSPHL/CHS/CHS-Data/BRFSS/BRFSS_homepage.htm
The CDC BRFSS website is http://www.cdc.gov/brfss/

Birth Certificates: Birth certificates are completed for all births that occur in Washington State. Births that occur to Washington residents in other states are added to the data files. Data presented in this report reflect information on Washington residents whether they delivered in WA or elsewhere. Information collected includes maternal and paternal demographics, delivery information, medical risks of the mother and selected morbidity of the newborn. For more information about data collected on the Washington State Birth Certificate, see the website http://www.doh.wa.gov/ehsphl/chs/chs-data/birth/bir_main.htm

Information on all births in the United States is collected and reported by the National Center for Health Statistics. Documentation, statistics and reports are available at www.cdc.gov/nchs/births.htm

Comprehensive Hospital Abstract Reporting System (CHARS): The Comprehensive Hospital Abstract Reporting System is a database maintained by the Center for Health Statistics with inpatient hospital discharge information for all patients treated in state-licensed acute care hospitals in Washington from 1987-2004, regardless of patient residence. A hospital is defined as any health care institution that is required to qualify for a license under RCW 70.41.020. CHARS does not cover private alcoholism hospitals, no-fee hospitals, US military hospitals, US Veterans Administration (VA) hospitals, or Washington State psychiatric hospitals. Data on Washington residents hospitalized in Oregon are obtained through the Oregon Hospital Discharge Data (OHDD). However, hospitalization data are not available for Washington residents hospitalized in other states, and OHDD cannot always be combined with CHARS, as for example, when one wants to count individuals and not hospitalizations. This situation affects border counties, especially those adjacent to larger population centers in other states. Asotin and Garfield counties are particularly affected by hospitalization in Idaho. Up to 9 hospital discharge diagnoses are recorded using the ninth revision of the International Classification of Disease diagnosis codes (ICD-9). Additional information is available at http://www.doh.wa.gov/EHSPHL/hospdata/

Current Population Survey (CPS): CPS is a monthly household survey of the non-institutional civilian population in the United States. Most of the information collected is on unemployment and the labor force (including employment benefits, such as health insurance coverage). Supplemental questions related to health have also been asked including tobacco use, fertility, and food security. The CPS Website is http://www.bls.census.gov/cps/cpsmain.htm

Death Certificates: Death certificates are completed for all deaths that occur in Washington State. In addition, deaths to Washington residents that occur out of state are added to the data files. Data presented in this report reflect Washington residents whether they died in Washington or not. Death certificate information includes demographics, characteristics of the death and causes of death. The causes of deaths reported here are classified based on the International Classification of Diseases, Tenth Revision (ICD-10) published by the World Health Organization. Information on this classification as well as continuity with the previous revision is available in the Vital Statistics Technical Note at www.doh.wa.gov/ehsphl/chs/chs-data/TechNote/Tech_not.pdf Additional information about data collected on the Washington State Death Certificate is available at: http://www.doh.wa.gov/EHSPHL/CHS/CHS-Data/death/deatmain.htm

Information on all deaths in the United States is collected and reported by the National Center for Health Statistics. Documentation, statistics and reports are available at http://www.cdc.gov/nchs/deaths.htm

Information on infant deaths in this report come from a data file that links deaths to infants less than 365 days old to birth certificates. This linkage provides maternal demographics, maternal pregnancy information and birth characteristics for the infant.

Fetal Death Certificates: Fetal Death certificates are completed for all fetal deaths of 20 weeks gestation or more that occur in Washington State. Fetal deaths that occur to Washington residents in other states are added to the data files. Information collected on the fetal death certificate includes maternal and paternal demographics, causes of fetal death, delivery information, pregnancy risks and selected morbidity of the mother, and congenital anomalies of the fetus. For more information about data collected on the Washington State Fetal Death Certificate, see the website http://www.doh.wa.gov/ehsphl/chs/chs-data/fetdeath/fd_main.htm

Information on all fetal deaths in the United States is collected and reported by the National Center for Health Statistics. Documentation, statistics and reports are available at http://www.cdc.gov/nchs/about/major/fetaldth/abfetal.htm

First Steps Database: The First Steps Database (FSDB), housed in Research and Data Analysis, Department of Social and Health Services, was created to assist in the evaluation of the First Steps Program. The First Steps Program helps low-income pregnant women get the health and social services they need. The FSDB performs an annual individual-level linkage of Medicaid claims and eligibility data with birth and death certificates. Medicaid women are defined by FSDB as women who received Medicaid-paid prenatal care and/or delivery services or who were enrolled in a Medicaid managed care plan for at least 3 of the last 6 months before delivery. (See Medicaid Status under Technical Notes and Definitions below for additional information on the classification of women on Medicaid used in this report). Documentation, statistics and reports are available at http://fortress.wa.gov/dshs/maa/FirstSteps/FSDB.htm

Genetics Minimum Data Set: The Genetics Minimum Data Set is maintained by the Genetics Program at the Office of Maternal and Child Health. The dataset includes genetic service utilization data for all regional genetic clinics in Washington with information on the demographics of the population served.

Healthy People 2010 Objectives: Healthy People 2010 provides national health objectives for a number of health outcomes to be achieved by 2010. Documentation, baseline data and objectives can be found at http://www.healthypeople.gov/document/

Healthy Youth Survey: The Healthy Youth Survey (HYS) is a collaborative effort of the Office of the Superintendent of Public Instruction, the Department of Health, the Department of Social and Health Service's Division of Alcohol and Substance Abuse, and the Department of Community, Trade and Economic Development. Data on youth substance use and other health behaviors are needed to support planning and evaluation of science-based prevention and health promotion programs. Historically, numerous surveys were administered by different groups (See description of Survey of Adolescent Health Behaviors and the Youth Risk Behavior Survey). The Healthy Youth Survey was developed to better coordinate survey efforts and minimize the burden on schools. HYS was first administered in October 2002, and will now be administered every two years in the fall. It provides information about adolescents in grades 6, 8, 10 and 12 in public schools in Washington. Schools are randomly sampled and all students in the surveyed grades are asked to respond to the questionnaire. Topics include safety and violence, physical activity and diet, alcohol, tobacco and other drug use, and related risk and protective factors. Documentation and state level data are available at: http://www3.doh.wa.gov/HYS/

National Immunization Survey: The National Immunization Survey is an ongoing telephone survey of a random sample of households screened to determine whether an infant 19-35 months lives there. The adult most knowledgeable about the infant's health is surveyed to provide demographic information and to identify the provider(s) of immunizations. A mailed survey is sent to the providers for immunization history. The survey is conducted by the National Immunization Program and National Center for Health Statistics at the Centers for Disease Control and Prevention. The survey uses the state and local area integrated telephone survey (SLAITS) methodology. State level immunization rates are available. Documentation and reports are available at http://www.cdc.gov/nis

National Survey of Children's Health: The National Survey of Children's Health was a telephone survey of a random sample of households with children less than 18 conducted from January 2003-July 2004. One child from the household was randomly selected to be the subject of the survey. The adult most knowledgeable about the child's health is asked to respond to the survey. The survey asked about the physical, social and emotional health of children. The survey was conducted by the National Center for Health Statistics at the Centers for Disease Control and Prevention. The survey used the state and local area integrated telephone survey (SLAITS) methodology. State level data are available. Planning is underway for another National Survey of Child Health to be conducted in 2007. Documentation and reports are available at http://www.cdc.gov/nchs/about/major/slaits/nsch.htm

National Survey of Children with Special Health Care Needs: The National Survey of Children with Special Health Care Needs was a telephone survey conducted from October 2000 – April 2002. A random sample of households was selected and screened to identify children with special needs. The adult most knowledgeable about the selected child's health was asked to respond to the survey which collected information on health insurance, access to services, satisfaction with care and care coordination. The survey was conducted by the National Center for Health Statistics at the Centers for Disease Control and Prevention. The survey used the state

and local area integrated telephone survey (SLAITS) methodology. State level data are available. Another National Survey of Children with Special Health Care Needs is underway and data collection will be completed in 2006. Documentation and reports for the 2001 survey are available at http://www.cdc.gov/nchs/about/major/slaits/cshcn.htm Documentation and reports for the 2005-2006 survey are available at http://www.cdc.gov/nchs/about/major/slaits/cshcn_05_05.htm

National Vital Statistics Reports: The National Center for Health Statistics publishes periodic reports based on national birth and death data including annual reports summarizing trends in US births and deaths. Documentation and reports are available at http://www.cdc.gov/nchs/products/pubs/pubd/nvsr/nvsr.htm

Pregnancy Risk Assessment Monitoring System (PRAMS): The Pregnancy Risk Assessment Monitoring System survey is an ongoing, population-based surveillance system sponsored by the Centers for Disease Control and Prevention (CDC) and the Washington State Office of Maternal and Child Health. PRAMS is designed to generate state-specific data for assessing health status and health care before, during, and after pregnancy. Some of the topics include prenatal care, pregnancy intention, multivitamin use, tobacco and alcohol use, physical abuse, breastfeeding, infant health care and infant sleep position. The information can be used for health and social services planning and policy development. Documentation and the questionnaire are described at http://www.doh.wa.gov/cfh/PRAMS/default.htm Additional detail is available at the CDC PRAMS webpage http://www.cdc.gov/reproductivehealth/srv_prams.htm

Smile Survey: The Washington State Smile Survey is conducted by the Department of Health every five years. During the most recent survey, thirty nine Head start or ECEAP sites and sixty-seven public elementary schools with a 2nd or 3rd grade were randomly selected across the state during the 2004-2005 school year. All preschool children enrolled and present on the day of the screening were included in the sample unless the parent returned a consent form specifically opting out of the sample. Elementary schools could choose to use either an active or passive consent process. Each child participating in the survey received an oral screening exam to determine the child's caries experience, treatment need and urgency, and dental sealants needs. Many counties chose to supplement this survey with an over sample or census of schools and/or Head Start/ECEAP sites in their county. More information on the Smile Survey is available at http://devwww/cfh/Oral_Health/index.htm

State and Local Area Integrated Telephone Survey (SLAlTS): This is a survey methodology for collecting state level health care data for program development and policy-making activities. The National Center for Health Statistics has employed this methodology for several national surveys, including the National Survey of Child Health, National Immunization Survey, and the National Survey of Children with Special Needs. Information about this methodology is available at http://www.cdc.gov/nchs/slaits.htm#Description

United States Census: Current Washington State census data are available from the Washington State Office of Financial Management at http://www.ofm.wa.gov/census2000/index.htm Current United States census data are available from the US Census Bureau at http://www.census.gov

VISTA: VistaPHw is a menu-driven software application that allows the user to analyze population-based health data for Washington. Data available in VistaPHw include vital statistics, hospital discharge data, sexually-transmitted disease data, tuberculosis data, and census

data. VistaPHw allows analysis of rates by age group, race, gender, time period, and geographic location. VistaPHw has been used for some analyses in this report because of the ease of use. In these cases, VistaPHw has been cited as the data source. Some minor differences between analyses using VistaPHw and Vital Statistics data files may occur due to differences in data definitions. Documentation on VistaPHw is available at http//www.doh.wa.gov/OS/Vista/HOMEPAGE.HTM

Washington State Population Survey: The Washington State Population Survey is a telephone survey of a random sample of Washington households which has been conducted every two years since 1998. The survey is coordinated by the Washington State Office of Financial Management. The survey focuses on employment, family poverty, in-migration, health and health insurance coverage. Additional information is available at http://www.ofm.wa.gov/sps/index.htm

Survey of Adolescent Health Behaviors: The Survey of Adolescent Health Behaviors in 2000 was a precursor to the current Healthy Youth Survey. The survey was conducted jointly by the Department of Social and Health Services, the Office of the Superintendent of Public Instruction, the Department of Community Trade and Economic Development, and the Department of Health Tobacco Program. The survey was administered during class time to public school students in grades 6, 8, 10 and 12. The sample was stratified by geographic region and school size, and within these cells, where possible, a school was selected from each of three community types: urban, suburban, and rural. All students in selected schools were invited to participate. The survey asked a variety of questions about alcohol, tobacco, and drug use and risk and protective factors.

Youth Risk Behavior Survey: The 1999 Washington State Youth Risk Behavior Survey (YRBS) was a precursor to the current Healthy Youth Survey based on the Centers for Disease Control and Prevention Youth Risk Behavior Survey instrument. The YRBS is intended to monitor adolescent health-risk behaviors that contribute to morbidity, mortality, and social problems among youth and adults in the United States. The Washington YRBS used a two-stage sampling design: schools were chosen using a probability-proportionate-to-size sampling of all public schools serving children grades 9-12 (which ensured that smaller schools had some chance of selection). Once schools were chosen, a random sample of classrooms was selected within participating schools. A sample of 4,022 adolescents in Washington State public schools participated in the YRBS 1999 survey. Alternative schools serving high-risk youth in the public school system were included. Based on four comparison items that were also administered to a census of eleventh graders in the state during achievement testing, results seemed to be representative of adolescents in public schools despite the low school participation rate (45%). Additional information on Washington's Youth Risk Behavior Survey is available at www.doh.wa.gov/EHSPHL/Epidemiology/NICE/publications/yrbs99.pdf The CDC YRBS webpage is http://www.cdc.gov/HealthyYouth/yrbs/index.htm

Technical Notes and Definitions

Confidence Interval: A confidence interval is a range of values that is used to describe the uncertainty around a point estimate of a quantity, for example, a mortality rate or the frequency of a particular behavior. Confidence intervals measure the variability in the data. Generally speaking, confidence intervals describe how much different the point estimate could have been if the underlying conditions stayed the same, but chance had led to a different set of data. Confidence intervals are calculated with a stated probability (say 95%), and we say that there is a 95% chance that the confidence interval covers the true value. Most confidence intervals are calculated as 95% confidence intervals because it's conventional and that is the level we use in this report. It is good to remember that the true population value is a constant, but its value is unknown. Thus, we calculate a confidence interval based on the sample of data we have available. If we had generated 100 confidence intervals, from taking 100 samples of data, each time the data would be slightly different and the confidence interval would be different. However, approximately 95 of the 100 confidence intervals would contain the true value. Confidence intervals do not account for bias resulting from missing or incomplete data, non-response to a survey, or poor data collection. This report provides confidence intervals for all survey data, including data from the Pregnancy Risk Assessment Monitoring System (PRAMS), the Healthy Youth Survey, the Behavior Risk Factor Surveillance System, the National Survey of Children's Health, the National Survey of Children with Special Needs, the National Immunization Survey, the Washington State Smile Survey and the Washington State Population Survey.

Much of this information was taken from the *Washington State Department of Health - Assessment Guidelines* (or http://www.doh.wa.gov/data/guidelines/ConfIntguide.htm) website.

International Classification of Disease (ICD) Codes: ICD codes are used to code hospitalization data in the Comprehensive Hospital Abstract Reporting System (CHARS) dataset and to code cause of death in the death certificate data. Hospitalization data use the ninth revision of the codes (ICD-9). Starting in 1999, mortality data switched from using ICD-9 to using the tenth revision of the codes (ICD-10). In order to view trends in Death Certificate data, comparability ratios (available from the National Center for Health Statistics) are used.

Medicaid Status: The source for the Medicaid designations used in this report is the First Steps Database (FSDB). FSDB uses three major Medicaid subgroups, determined by eligibility at the time of delivery: S Women Citizens, TANF, and Non-Citizens. In addition to these major groups, a small number of Medicaid women are eligible through other Medicaid programs, or receive services with eligibility type unknown.

- **S Women Citizens** – S Women citizens are Medicaid-eligible solely because of pregnancy (program S, excluding non-citizens). They have incomes at or below 185% of the Federal Poverty Level.
- **TANF -** Women on Temporary Assistance for Needy Families (TANF) receive cash grants in addition to medical coverage (program C or E). They generally have family incomes lower than 50% of the Federal Poverty Level.
- **Non-Citizens** – Non-Citizen women have incomes at or below 185% of the Federal Poverty Level, are Medicaid-eligible solely because of pregnancy, and are not legally

admitted for permanent residence in the United States. Non-Citizens are not eligible for TANF although their incomes are often lower than women on TANF.

In this report, Medicaid status is used as a proxy for socioeconomic status. From highest to lowest socioeconomic status the groups are: Non-Medicaid women, S Women, TANF and Non-Citizens. For additional information on the Medicaid groups, see First Steps Database description above or the First Steps website http://fortress.wa.gov/dshs/maa/FirstSteps/FSDB.htm

Race and Ethnicity: Rates in this report are presented by race and ethnicity because we observe disparities across these groups in Washington. Race/ethnic disparities are believed to reflect a mix of social, cultural and economic factors, not biology. One of the Healthy People 2010 goals is to reduce race/ethnic disparities and to monitor progress toward this goal, we must collect and present data by race/ethnicity. Current federal guidelines separate Hispanic ethnicity from race, and report on race and ethnicity separately. Federal guidelines also currently specify using five racial groups: White, Black or African American, Asian, Native Hawaiian or Pacific Islander, and American Indian or Alaska Native. We attempted to use a standard race/ethnicity coding system that followed the federal guidelines, but the data sources used in this report use five different grouping systems.

Data from the birth certificate use the federal guidelines and include the five race groups: White, Black, Asian, Native Hawaiian or Pacific Islander, and American Indian/Alaska Natives as well as a breakdown for Hispanics and Non-Hispanics. Data presented this way includes low birth weight, prenatal care, preterm delivery and smoking during pregnancy.

Washington State population files group Asians with Native Hawaiian or Pacific Islanders. Thus, the adolescent pregnancy, intentional injury, child mortality and unintentional injury chapters use four race groups and the Hispanic ethnicity breakdown.

The Healthy Youth Survey determines race/ethnicity from one question so data based on this survey can not analyze race separately from ethnicity. Data from the Healthy Youth Survey have 7 groups: White, Black, Asian, Pacific Islander, Native American, Hispanic and Other. These data include: asthma, child weight and physical activity, food insecurity and hunger, and mental health.

The Pregnancy Risk Assessment Monitoring System (PRAMS) samples respondents based on their race/ethnicity. Thus, data from PRAMS reports on the five sampled groups: Hispanics, and Non-Hispanic Whites, Non-Hispanic Blacks, Non-Hispanic Asian/Pacific Islanders, and Non-Hispanic American Indian/Alaska Natives. These data include alcohol use during pregnancy, perinatal behaviors and births from unintended pregnancies.

The 2005 SMILE Survey reports data on Non-Hispanic Whites, Non-Hispanic African Americans, Non-Hispanic Asians, Non-Hispanic Native Americans, and Hispanics.

Lastly, the National Survey of Children's Health and the National Survey of Children with Special Health Care Needs report data on Whites, Blacks, Multiple Race and Other.

Rates: A crude rate is the number of health events in a specified place and time period divided by the number of people at risk for the health event in the same place and time. For example, the Washington child mortality rate in 2003 is the number of Washington children ages 1-19 who died in 2003 divided by the total number of Washington children ages 1-19 in 2003. Rates are

usually multiplied by a constant such as 1,000 or 100,000 for ease of understanding, and are then reported as rate per 1,000 or rate per 100,000. Thus, child mortality is usually reported as deaths per 100,000 children 1-19 years. For additional information on calculating and interpreting rates, please see the Washington State Department of Health data guidelines at http://www.doh.wa.gov/Data/guidelines/Rateguide.htm

Rural/Urban Classification: Research has shown that there are differences in health status between residents of rural and urban Washington. Disparity data by urban or rural residence presented in this report uses the Rural Urban Commuting Area (RUCA) codes. This classification system developed by the US Department of Agriculture is based on census tract geography. Both population size and commuting relationships are used to classify census tracts. The RUCA codes used in this report are based on the 2000 census data.

Ideally, we would classify small areas such as census tracts or zip codes according to their RUCA classification and then proceed to compare health outcomes of the urban areas to the rural areas. Because the population data at this geographic level for 2001-2003 was not yet linked to RUCA codes, county level analysis was done and each county was assigned a RUCA code. The Washington State Office of Community and Rural Health developed a five-tiered consolidation of RUCA codes for general analyses of county-level data:

- **Urban / Urban fringe** - At least 75% of the county population in 2000 resided in urbanized census tracts.
- **Mixed Urban** – Between 50% and 75% of the county population in 2000 resided in urbanized census tracts or tracts where more than 30% of the commuter flow was to an urbanized area
- **Large Town Rural** – At least 75% of the county population in 2000 resided in a large town census (10,000 to 49,999) tract or tracts where more than 30% of the commuter flow was to a large town area
- **Mixed Rural** – Between 50% and 75% of the county population in 2000 resided in a large town (10,000 to 49,999) or small town (no town over 9,999) census tract or tracts where more than 30% of the commuter flow was to these areas
- **Small town rural** - At least 75% of the county population in 2000 resided in a small town or isolated (no town over 9,999) census tract or tracts where more than 30% of the commuter flow was to a small town area

For more information on Rural-Urban classifications, see the USDA site at http://www.ers.usda.gov/briefing/Rurality/RuralUrbanCommutingAreas/

More information on the RUCA system is also available at: http://www.doh.wa.gov/Data/Guidelines/RuralUrban.htm#4tier

Small numbers: To protect confidentiality in this report, rates are not presented if the number of health events was five or less. To prevent the need to suppress a lot of rates, where possible we have combined three years of data for the sub-group analyses: county, age, race/ethnicity and rural/urban classification. The interpretation of data based on small numbers is another concern. Small numbers primarily affects the county-specific rates, and can lead to instability of rates even when three years of data are used. We have provided county population data in the first

section of the report and encourage readers to look at the population sizes and estimate the number of events prior to using the data for policy and program planning.

Unintended Pregnancy: The percent of pregnancies which are unintended. Unintended pregnancy attempts to count the proportion of all pregnancies that were not intended at the time of conception. The only Washington State data available to assess intention are data from the Washington State Pregnancy Risk Assessment Monitoring System (PRAMS). In PRAMS, to determine pregnancy intention, women are asked 2-6 months after delivering a live birth how they felt about becoming pregnant when they first learned of their pregnancy. Women can respond they wanted to be pregnant sooner, later, at that time or they didn't want to be pregnant then or at any time. Responses that the woman wanted to be pregnant later or not at any time are considered unintended. In addition, all abortions are considered unintended pregnancies. The unintended pregnancy rate is calculated as follows. The numerator is [(the estimated percentage of unintended pregnancies from PRAMS) *(resident live births)] + reported resident abortions. The denominator is the number of resident live births + reported resident abortions. Birth and Abortion data are obtained from the Washington State Center for Health Statistics Birth and Abortion files for 2001-2003.

There are several concerns with the unintended pregnancy measure. First, information on intention is only collected from some pregnancies (live births) and not from fetal deaths, abortions or other pregnancy outcomes. Second, the reported pregnancy intention may vary depending on when in relation to the pregnancy it is asked. Third, the concept of intending or planning pregnancies may be influenced by cultural perceptions around pregnancy and the life course.

Appendix B: Office of Maternal and Child Health Priority Needs 2005-2009

1) Appropriate nutrition and physical activity for the MCH population

2) Lifestyle free of substance use and addiction among adolescents and women

3) Optimal mental health and healthy relationships.

4) Healthy physical and social environments/communities for the MCH population

5) Safe environments/communities for the MCH population

6) Healthy physical, emotional, cognitive, and social development for all children

7) Sexually responsible and healthy adolescents and women

8) Access to preventive and treatment services for the MCH population

9) Screening, identification, intervention, and care coordination for the MCH population

Appendix C:
State and National Performance Measures, MCH Block Grant

State Performance Measures

	Year	Rate
SP 1. The percent of pregnancies (live births, fetal deaths, abortions) that are unintended.	2003	55
SP 2. The percent of pregnant women abstaining from smoking.	2003	89
SP 3. The percent of women who receive counseling from their prenatal health care provider on tests for identifying birth defects or genetic disease.	2002	89
SP 4. Establish a sustainable strategy for assessing the prevalence of children with special health care needs		Process Measure
SP 5. The rate of youth using tobacco products	2003	9.2
SP 6. The percent of women who are screened for domestic violence during their prenatal care visits.	2002	46
SP 7. Increase the capacity of OMCH to assess mental health needs of the child and adolescent population and to promote early identification, prevention and intervention services.		Process Measure
SP 8. The percent of women who are screened during prenatal care visits for smoking, alcohol use, illegal drug use, HIV status, and postpartum birth control plans.	2002	56
SP 9. Develop and implement a set of measurable indicators and a strategic plan to improve nutrition status among the MCH population, initially focusing on food security; that is, absence of skipped meals or hunger due to lack of food.	2003	Process Measure
SP 10. Increase statewide system capacity to promote health and safety in child care.		Process Measure

Appendix C: National Performance Measures

	Year	Rate
Percent of newborns in the State screened for conditions mandated by their State-sponsored newborn screening programs (e.g. PKU and hemoglobinopathies) and receive appropriate follow-up care as defined by their State	2003	89.3
The percent of children with special health care needs age 0 to 18 whose families partner in decision-making at all levels and are satisfied with the services they receive	2003	54.9
The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home.	2003	53.6
The percent of children with special health care needs whose families have adequate private and/or public insurance to pay for the services they need.	2003	64.4
The percent of children with special health care needs age 0 to 18 whose families report the community-based service system are organized so they can use them easily.	2003	74.1
The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life.	2003	5.8
Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertusis, haemophilus Influenza, Hepatitis B.	2003	75.3
The birth rate (per 1,000) for teenagers ages 15 through 17 years.	2003	15.3
Percent of third grade children who have received protective sealants on at least one permanent molar tooth.	2003	55.5
The rate of deaths to children ages 1-14 caused by motor vehicle crashes per 100,000 children.	2003	2.9
Percentage of mothers who breastfeed their infants at hospital discharge.	2002	87
Percentage of newborns that have been screened for hearing impairment before hospital discharge.	2004	85.0
Percent of children without health insurance.	2004	6.0
Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.	2003	88.9
Percent of very low birth weight live births.	2003	1.0
The rate (per 100,000) of suicide deaths among youths 15-19.	2003	9.6
Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.	2003	83.4
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.	2003	81.5

Appendix C: Federal Outcome Measures, MCH Block Grant

	Year	Rate
1. The infant mortality rate per 1,000 live births.	2003	5.6
2. The ratio of the black infant mortality rate to the white infant mortality rate.	2003	1.7
3. The neonatal mortality rate per 1,000 live births.	2003	3.8
4. The postneonatal mortality rate per 1,000 live births	2003	1.8
5. The perinatal mortality rate per 1,000 live births	2003	9.1
6. The child death rate per 100,000 for children ages 1-14	2001	18.5

New State Performance Measures, 2005-2009

	Year	Rate
SP 1. The percent of pregnancies that are unintended.	2005	
SP 2. The percent of pregnant women abstaining from smoking.	2005	
SP 3. The percent of women who are screened during prenatal care for smoking, alcohol use, illegal drug use, HIV status, postpartum birth control plans, domestic violence and receive counseling on tests for birth defects or genetic diseases.	2005	
SP 4. Percent of children and youth who have people they can turn to for help when they feel sad or hopeless.	2005	
SP 5. Increase use of Bright Futures materials and principles by health, social service and education providers in Washington State.	2005	Process Measure
SP 6. Reduce the proportion of children 6-8 years old with dental caries experience in primary and permanent teeth.	2005	
SP 7. Increase statewide system capacity to promote health, safety, and school readiness of children birth to kindergarten entry.	2005	Process Measure

Health Status Indicators, MCH Block Grant

Core Health Status Indicators

Development Health Status Indicators

Please see Health Status Indicator Notes for more information. The notes are posted on the Maternal and Child Health (MCH) Assessment webpage.

C1	The rate of children hospitalized for asthma (ICD-9 Codes: 493.0-494.9) per 10,000 children less than five years of age.	2003	25.8%
C2a	The percent of Medicaid enrollees less than one year during the reporting year who received at least one initial or periodic screens.	2003	98.6%
C2b	The percent of State Children Health Insurance Program (SCHIP) enrollees whose age is less than one during the reporting year who receive at least one periodic screen.	2001	85.0%
C3	The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.	2003	66.3%
C4a	The percent of live births weighing less than 2,500 grams	2003	6.0%
C4b	The percent of live singleton births weighing less than 2,500 grams.	2003	4.6%
C5a	The percent of live births weighing less than 1,500 grams.	2003	1.0%
C5b	The percent of live singleton births weighing less than 1,500 grams.	2003	0.8%
C6a	Percent of low birth weight by	2003	6.6%, 5.5%, 6.0%

	Medicaid enrollees, non-Medicaid enrollees and total population.		
C6b	Percent of infant deaths per 1,000 live births by Medicaid enrollees, non-Medicaid enrollees and total population.	2003	6.7%, 4.4%, 5.4%
C6c	Percent of pregnant women entering care in the first trimester by Medicaid enrollees, non-Medicaid enrollees and total population.	2003	72.3%, 89.6%, 81.6%
C6d	Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80%, Kotelchuck index) by Medicaid enrollees, non-Medicaid enrollees and total population.	2003	62.0%, 73.3%, 68.1%
D1a	The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.	2003	7.2
D1b	The death rate per 100,000 due to unintentional injuries due to motor vehicle crashes among children aged 14 years and younger.	2003	2.9
D1c	The death rate per 100,000 due to unintentional injuries due to motor vehicle crashes among youth aged 15 years through 24 years.	2003	18.8
D2a	The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.	2003	134.8
D2b	The rate per 100,000 of all nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.	2003	23.8

D2c	The rate per 100,000 of all nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.	2003	116.3
D3a	The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.	2004	13.1
D3b	The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.	2004	15.2
D4	The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.	2003	55.0
D5	The percent of State SSI beneficiaries less than 16 years old receiving rehabilitation services from State Children with Special Health Care Needs (CSHCN) programs.	2004	7.7%
D9			
	Percent of children 0-19 years in households headed by single parent.	2004	24.8%
	Percent of children 0-19 years in TANF.	2003	10.0%
	Number of children 0-19 years enrolled in Medicaid.	2003	715,168
	Number of children 0-19 years enrolled in CHIP.	2003	15,276
	Number of children 0-19 years in Foster Care by race.	2003	10,994
	Number of children 0-19 years in Food Stamp Program.	2003	298,576
	Number of children 0-19 years in WIC.	2004	150,773
	Rate (per 100,000) of juvenile crime arrests for children 0-19 yrs.	2003	2,524
	Percent of High School Drop Outs, grades 9-12.	2003	6.7